S. HRG. 117–734

THE HOSPITAL INSURANCE TRUST FUND AND THE FUTURE OF MEDICARE FINANCING

HEARING

BEFORE THE

SUBCOMMITTEE ON FISCAL RESPONSIBILITY AND ECONOMIC GROWTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

FEBRUARY 2, 2022

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PUBLISHING OFFICE
53–384—PDF WASHINGTON : 2023

COMMITTEE ON FINANCE

RON WYDEN, Oregon, *Chairman*

DEBBIE STABENOW, Michigan	MIKE CRAPO, Idaho
MARIA CANTWELL, Washington	CHUCK GRASSLEY, Iowa
ROBERT MENENDEZ, New Jersey	JOHN CORNYN, Texas
THOMAS R. CARPER, Delaware	JOHN THUNE, South Dakota
BENJAMIN L. CARDIN, Maryland	RICHARD BURR, North Carolina
SHERROD BROWN, Ohio	ROB PORTMAN, Ohio
MICHAEL F. BENNET, Colorado	PATRICK J. TOOMEY, Pennsylvania
ROBERT P. CASEY, JR., Pennsylvania	TIM SCOTT, South Carolina
MARK R. WARNER, Virginia	BILL CASSIDY, Louisiana
SHELDON WHITEHOUSE, Rhode Island	JAMES LANKFORD, Oklahoma
MAGGIE HASSAN, New Hampshire	STEVE DAINES, Montana
CATHERINE CORTEZ MASTO, Nevada	TODD YOUNG, Indiana
ELIZABETH WARREN, Massachusetts	BEN SASSE, Nebraska
	JOHN BARRASSO, Wyoming

JOSHUA SHEINKMAN, *Staff Director*
GREGG RICHARD, *Republican Staff Director*

SUBCOMMITTEE ON FISCAL RESPONSIBILITY AND ECONOMIC GROWTH

ELIZABETH WARREN, Massachusetts, *Chair*

RON WYDEN, Oregon	BILL CASSIDY, Louisiana
	RICHARD BURR, North Carolina

CONTENTS

OPENING STATEMENTS

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

THE HOSPITAL INSURANCE TRUST FUND AND THE FUTURE OF MEDICARE FINANCING

WEDNESDAY, FEBRUARY 2, 2022

U.S. SENATE,
SUBCOMMITTEE ON FISCAL RESPONSIBILITY
AND ECONOMIC GROWTH,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:30 p.m., via Webex, in Room SD–215, Dirksen Senate Office Building, Hon. Elizabeth Warren (chair of the subcommittee) presiding.

Present: Senators Cassidy, Whitehouse, and Daines.

Also present: Democratic staff: Catherine Laporte-Oshiro, Economic Policy Advisor for Senator Warren; and Tess Byars, Health Policy Advisor for Senator Warren. Republican staff: Katie Rudis-Hadji, Legislative Director and General Counsel for Senator Cassidy; Brian Looser, Health Policy Advisor to Senator Cassidy; and Mary Moody, Health Policy Advisor to Senator Cassidy.

OPENING STATEMENT OF HON. ELIZABETH WARREN, A U.S. SENATOR FROM MASSACHUSETTS, CHAIR, SUBCOMMITTEE ON FISCAL RESPONSIBILITY AND ECONOMIC GROWTH, COMMITTEE ON FINANCE

Senator WARREN. May we come to order? Good afternoon, and welcome to today's hearing before the Subcommittee on Fiscal Responsibility and Economic Growth. Bear with us.

I am pleased to be working with Ranking Member Cassidy on the hearing, "The Hospital Insurance Trust Fund and the Future of Medicare Financing." That title may sound a little dry, so let me be more direct.

This hearing is about Medicare finances, both how to strengthen the current system and how to pay for expanded coverage to include vision, dental, and hearing. The short version is this: the Medicare system is hemorrhaging money on scams and frauds. It is critical that we stop the flow, and, if we do, the system will have more than enough money to operate at its current level and increase coverage.

Where do we begin? Well, how about with giant drug manufacturers? In 2019, total Medicare spending on prescription drugs was $220 billion. Since Medicare is a very high-volume buyer, you would think that the Medicare program would be getting a great deal on pricing—but you would be wrong.

Because Medicare cannot negotiate prices, drug companies are able to rake in billions in profits. Now that is bad enough, but the

drug companies have more ways to juice their profits. They use anticompetitive tactics like pay-for-delay, product hopping, and patent thickening, all while antitrust regulators turn a blind eye. It is enough to gag a maggot.

There is so much we could do to improve Medicare finances. For example, we could save Medicare as much as $130 billion over 10 years just by strengthening enforcement of our antitrust laws and ending one—just one—type of industry ripoff.

Or consider another option. We could rein in greedy private insurers that take advantage of the Medicare Advantage program. Now, Medicare Advantage was a back-door effort to privatize the Medicare program. It was built on vague promises of cost savings, but instead it has cost Medicare almost $150 billion extra over the past 12 years because greedy private insurers are gaming the program's rules, including its risk-adjustment process, its benchmark policy, and its quality bonus program, all to squeeze more money out of Medicare and to drive up the cost for taxpayers.

Medicare could save nearly $800 billion over 10 years just by ending these scams. Together, just those few changes alone would save Medicare over $900 billion over 10 years. And just to put that in perspective, the estimated shortfall in the hospital insurance trust fund is $517 billion between 2026 and 2031. And the cost of extending Medicare coverage to include dental, vision, and hearing to the program is just under $360 billion.

In other words, we do not need to cut Medicare benefits. We need to cut out the scams that are bringing Medicare down. The number of corporate vultures hoping to feed on Medicare continues to grow. Even today, in the Biden administration, CMS has invited the same insurers that are already scamming Medicare and dozens of new investor-owned organizations to cover traditional Medicare beneficiaries through a new privatized Direct Contracting model that lets them pocket—get this—as much as 40 percent in profits. This invites fiscal disaster, and I hope this administration will reverse this decision.

Yes, we need to make changes to Medicare, but not the cuts and privatization that my Republican colleagues have sought in past efforts to, quote, "reform" Medicare. No. Instead of undermining the system and the benefits that we deliver, we need to crack down on greedy drug manufacturers, on private insurers, and on private equity firms. We need drug price negotiation, and we need better oversight of the Medicare Advantage program so that for every dollar spent, a Medicare beneficiary actually gets a dollar's worth of value. And with more than $900 billion that we could save, we need to expand Medicare coverage to include dental, vision, and hearing benefits for all of our seniors and people with disabilities who are part of the program. That is how we build a healthier America.

Now, I look forward today to discussing these issues. I appreciate all of our witnesses who are joining us, and I look forward to hearing about their experiences and their insights.

[The prepared statement of Senator Warren appears in the appendix.]

Senator WARREN. So let us get started with the witness introductions. Ranking Member Cassidy is going to join us for his opening

statement just a little bit later. But we have a great set of witnesses here today to share their views on Medicare financing, and I very much appreciate their attendance today.

First, joining us virtually, we have Dr. Michael Chernew. Dr. Chernew is the Chair of the Medicare Payment Advisory Commission, which is the independent congressional agency that was established to advise Congress on issues affecting the Medicare program.

Second, joining us remotely, we have Dr. Susan Rogers, the president of Physicians for a National Health Program. She is also an assistant professor of medicine at Rush University, and she recently retired from the Stroger Hospital of Cook County.

Third, also joining us virtually, we have Professor Amy Kapczynski. She is a professor of law at Yale Law School, and serves as faculty co-director of the Global Health Justice Partnership and the Law and Political Economy Project. Her research focuses on information policy, intellectual property, international law, and global health.

Next, joining us remotely, we have Katherine Baicker, dean and professor of the University of Chicago Harris School of Public Policy. Professor Baicker studies the effectiveness of public and private health insurance, including the effect of reforms on the distribution and the quality of care.

And then finally, our fifth witness joining us virtually, we have James Capretta, senior fellow at the American Enterprise Institute, and senior advisor at the Bipartisan Policy Center.

So, I want to thank you all for joining us here today. I look forward to hearing your testimony.

Dr. Chernew, could we start with you, please? I will recognize you for 5 minutes.

STATEMENT OF MICHAEL E. CHERNEW, Ph.D., CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION, WASHINGTON, DC

Dr. CHERNEW. Thank you, Chair Warren and Ranking Member Cassidy, Senators, and staff. Thank you very much for the opportunity to speak with you today on behalf of MedPAC about Medicare solvency and the future of Medicare financing.

Before I launch into the main thrust of my comments, I would like to acknowledge the enormous hold that the pandemic has placed on all Americans, particularly Medicare beneficiaries and the clinicians and health-care workers who have been on the front lines of the pandemic for the last 2 years.

Turning to the topic at hand—Medicare's fiscal challenges—the hospital insurance Part A trust fund is projected to be exhausted around 2026 or 2027. The Medicare trustees estimate that it would take an immediate reduction in Part A spending of $70 billion to put Part A's financing on a stable footing.

However, Part A is only part of Medicare's fiscal problem. Spending on other parts of Medicare is also growing rapidly and contributes to Medicare's overall sustainability problems. I will be discussing policies related to both Part A sustainability and overall Medicare spending. It is important to start with context.

The core issue is that we are striving to give more and better care to more beneficiaries with relatively fewer workers to provide

financing. Around the time of Medicare's inception, there were 4.6 workers for every Medicare beneficiary. By 2029, there are expected to be only 2½ workers per beneficiary. This demographic challenge heightens the need to avoid paying more than needed to support beneficiary access to high-quality services, and to find ways to alter patterns of utilization to reduce spending while maintaining quality and access.

My written testimony outlines recommendations that address traditional fee-for-service Medicare, Medicare Advantage, and the Medicare Part D program. The first set of recommendations would reduce payments to certain providers that have historically been substantially overpaid under traditional fee-for-service Medicare. Most of these providers are funded through Part A, so these recommendations produce immediate savings for the Part A trust fund, and we assert that these payments will not compromise access to or quality of care. These recommendations appear in our annual March report.

Shifting to the Medicare Advantage program, this program allows beneficiaries enrolled in both Part A and Part B to receive benefits from private plans, rather than traditional fee-for-service Medicare. Medicare pays these plans a fixed monthly amount for each enrollee. It is adjusted up or down to reflect the characteristics and medical conditions of that enrollee. Although Medicare Advantage plans are able to provide Medicare coverage at a cost below fee-for-service, Medicare pays plans more for their enrollees than they would cost in fee-for-service.

This occurs for three main reasons. First, in low fee-for-service spending markets, MA payments are deliberately set at levels higher than fee-for-service spending to balance across markets, access to MA plans, and added benefits.

Second, MA plans are paid more if they serve sicker beneficiaries, giving plans a strong financial incentive to identify as many diagnoses as possible. Providers do not have the similar coding incentives in traditional fee-for-service, resulting in a risk-adjustment system that is poorly calibrated.

Third, Medicare pays Medicare Advantage plans more for achieving higher ratings in the Medicare Advantage quality bonus program, but we have found that this program likely does not lead to better outcomes for Medicare Advantage enrollees. If Medicare Advantage plans can provide the Medicare benefits for less than traditional fee-for-service, Medicare should pay them in a manner that allows the program to share in those efficiencies. This follows the general principle that if suppliers of goods and services can do so at a lower cost, payments should go down. MedPAC has made several recommendations to address the rates paid to Medicare Advantage plans that involve reforms to how benchmarks are calculated, the method for adjusting payments to reflect diagnostic coding, and the structure of the quality bonus program, all of which are described in more detail in my written testimony.

Moving to the Part D program, the Commission has long recognized the clinical value of prescription drugs and the importance of Part D in promoting access to needed medications. Part D is administered by private plans that receive a mix of capitated payments and cost-based reinsurance subsidies to finance the phar-

macy benefits. The reinsurance payments occur after an enrollee's prescription drug costs reach the catastrophic phase of the Part D benefit, shifting the cost liability onto the Medicare program. Medicare's payment for reinsurance has grown considerably, rising from less than half of the capitated payments in 2007 to nearly five times as large by 2020.

The design of the Part D program should be altered to both save money for Medicare and improve incentives around prescription drug pricing, plan design, and out-of-pocket spending. Our June 2020 report to the Congress outlined a comprehensive recommendation to redesign the Part D benefits to accomplish these goals.

In closing, thank you very much for the opportunity to talk with you today. MedPAC stands ready to help you address the difficult fiscal challenges faced by Medicare. We look forward to continued discussions, and I am happy to answer any questions you have.

Thank you.

[The prepared statement of Dr. Chernew appears in the appendix.]

Senator WARREN. Thank you, Dr. Chernew.

And now, Senator Cassidy, would you like to do your opening statement, or do you want me to do one more of our witnesses? One more of our witnesses—good.

Thank you, Dr. Chernew. Dr. Rogers, I would like to recognize you for 5 minutes, please.

STATEMENT OF SUSAN ROGERS, M.D., FACP, PRESIDENT, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, CHICAGO, IL

Dr. ROGERS. Thank you so much. And thank you for inviting me to join this hearing on this topic.

My name is Dr. Susan Rogers, and I am a general internist from Chicago, IL, and I am president of Physicians for a National Health Program, which is a national organization of more than 24,000 doctors that advocates for a single-payer health-care system. And I am also a proud beneficiary of traditional Medicare.

The current threat to Medicare is very real. What we now call traditional Medicare was created in 1965 to provide a safety net for seniors and the disabled, many of whom lived in poverty, and to provide equity in health care when it effectively desegregated our Nation's hospitals.

Today, even though it is the most popular, effective, and efficient health program in our Nation's history, traditional Medicare is at risk of being sold off to the highest bidder, with no input from seniors, health providers, or even members of Congress.

Now the privatization of Medicare began when President Nixon enacted the HMO Act in 1973, and privatization actually exploded in 2003 with the creation of Medicare Advantage, the version of Medicare run by commercial insurers. The common thread among these privatization experiments is the theory that inserting a middleman between Medicare and its health providers, between physicians and patients, will somehow save money or improve care. However, it has failed at both.

In fact, researchers estimate that Medicare overpaid Medicare Advantage insurers by more than $106 billion from 2010 to 2019. And that is money that could have been spent on seniors' care.

Despite decades of failure, CMS launched a new model of Medicare privatization called Direct Contracting, and instead of paying doctors directly, Medicare pays third-party middlemen called Direct Contracting Entities, or DCEs, a set amount to manage seniors' health. DCEs are then allowed to pocket what they do not pay for in services, which is a dangerous financial incentive to restrict and ration seniors' health care.

If you have not heard of Direct Contracting, that is by design. It was created in 2019 by the CMS Innovation Center, also called CMMI, which is authorized to conduct payment experiments and to scale them up to all of Medicare without input from Congress. Virtually any type of company can apply to be a DCE, including commercial insurers, venture capitalists, or physician groups.

Seniors on traditional Medicare can be automatically assigned to a DCE without their knowledge or understanding, if their primary care provider is affiliated with a DCE. Then, the only way for a senior to opt out is to change primary care physicians, making this actually a bait-and-switch program for seniors. Forcing seniors to switch physicians is not only a terrible burden, but it undermines the importance of the patient-physician relationship that clearly DCEs do not acknowledge.

The new model program is that DCE middlemen will somehow lower costs and improve coordination of care, but former CMS and CMMI officials estimate that DCEs may spend as little as 60 percent of their Medicare payments on patient care, keeping the other 40 percent as profit and overhead.

How this is an improvement on traditional Medicare I do not know, since Medicare spends 98 percent of its funds on health care.

As a physician, I understand that it is my duty and responsibility to help make the care decisions, along with my patients, and then coordinate that care. That role is not for investors to take from us. They do not coordinate care. They coordinate payments.

Medicare was designed as a lifeline for America's seniors and adults living with disability. We cannot let it become a playground for Wall Street investors. If middlemen in health care actually saved money and improved outcomes, the U.S. would not have the most expensive and ineffective health-care system in the world. We do not need to put seniors through another failed experiment to prove this.

So, like an old African proverb says, "If you keep doin' what 'cha been doin', you'll keep gettin' what you already got." So, we need to get back to what we know works, and that is traditional Medicare.

Thank you so much.

[The prepared statement of Dr. Rogers appears in the appendix.]

Senator WARREN. Thank you, Dr. Rogers.

Professor Kapczynski, I recognize you for 5 minutes.

STATEMENT OF AMY KAPCZYNSKI, PROFESSOR AND FACULTY CO-DIRECTOR, GLOBAL HEALTH JUSTICE PARTNERSHIP AND LAW AND POLITICAL ECONOMY PROJECT, YALE LAW SCHOOL, NEW HAVEN, CT

Ms. KAPCZYNSKI. Chair Warren, Ranking Member Cassidy, and distinguished members of the subcommittee, I appreciate the opportunity to testify today.

My name is Amy Kapczynski. I teach at Yale Law School, and today I want to talk about the problems high drug prices and abuses of power pose for the Medicare program and for Medicare beneficiaries.

In the last year, close to 40 percent of Americans reported that they did not take a medicine as prescribed because of the cost. This is nothing short of a crisis, and it is driven by drug prices that have been rising unchecked for decades.

From 1980 to 2018, pharmaceutical spending increased more than tenfold in real terms—so, excluding economy-wide inflation. Just last year, more than 100 drugs saw price increases beyond inflation. We have seen old drugs like insulin rise hundreds of percent in recent decades. The average new cancer drug in the United States today costs more than $175,000. And these prices for old and new drugs do not reflect in any logical way the benefits or the R&D costs.

So, for Medicare patients, high prices translate into unaffordable co-insurance bills and deductibles, and rising premiums. So one recent study, for example, showed that seniors on Medicare who have common chronic conditions like diabetes saw their out-of-pocket drug costs rise by over 40 percent between 2009 and 2019.

Seniors cannot afford these costs, and we are seeing people delay treatment and even die as a result. High drug prices are also a major challenge for Medicare financing. So, as Senator Warren mentioned, we see about $220 billion in drug costs for Medicare, and bringing down costs can result in enormous savings.

So just for one example, CBO estimated that the legislative approval of H.R. 3, the Elijah Cummings Lower Drug Costs Now Act, would save the program about $50 billion a year on average. And if we curbed patent abuses, we could do still better.

So why are drug prices so high in the U.S.? How should we think about this problem? The core is really quite simple. Drug companies have monopoly rights that permit them to set high prices, particularly when we have widespread insurance, and also mandates even to cover monopolized products. Companies also engage in anticompetitive conduct that exacerbates the problem.

So this is why, though most prescriptions in the U.S. are for generic drugs, spending is heavily concentrated on patented medicines, suggesting that 7 percent of drugs in Medicare Part D drive 60 percent of the spending. And Medicare, of course, is forbidden by law from negotiating for lower prices.

So the historic argument for these high prices has been R&D, but unfortunately prices, we know, are not set in relationship to R&D. They are set according to what the market can bear. And that is not about R&D costs, but it is about market power. So we see that the largest pharmaceutical companies, for example, spend signifi-

cantly more, and in some cases twice as much, on marketing as they do on R&D, even in a global pandemic.

We see old drugs like insulin—no new innovation—rising dramatically in price. And we see exploitative anticompetitive conduct like pay-for-delay deals to keep generic drugs off the market for several more years, or investment in patent lawyers rather than innovation to create thickets of patents that surround the drug and delay entry again of generic competition. So, there is a lot of concern in Washington today about inflation, and it is worth noting that this is a fundamentally inflationary environment and it has been for a long time. I think it is worth stressing some things about this.

One, it is very clear, in this context, that we are seeing inflation due to unregulated monopoly power. Two, it is causing enormous pain for ordinary Americans. And three, we know how to solve it in fact, and without causing sector-wide pain as other approaches might.

So, I want to just come to several recommendations. We do actually know how to solve this problem. Many other countries, in fact all other industrialized countries, have systems of fair pricing for medicines. Borrowing from those, we have had proposals that have become very well-developed now. And we should draw upon these and ensure that, to protect the future of the Medicare program and the future of Medicare beneficiaries, Congress passes legislation that is going to curb high launch prices by enabling HHS to negotiate fair prices and think about fair prices by looking at R&D costs, how much public funding there was, what the investment risk was, the benefit of the drug, all of those things, and then backing up those negotiations with strong enforcement measures—for example, the ability to allow generic competitors into a market if a company refuses to sell.

We should also have legislation that penalizes price spikes to prevent price gouging on existing drugs. We should explore legislation to curb anticompetitive patent thickening, and that would strengthen rules against pay-for-delay settlement deals. And we should also critically provide the FTC with more resources and authority to address anticompetitive conduct in the sector.

Thank you.

[The prepared statement of Ms. Kapczynski appears in the appendix.]

Senator CASSIDY [presiding]. Thank you, Ms. Kapczynski.

Professor Baicker, you are next.

STATEMENT OF KATHERINE BAICKER, Ph.D., DEAN AND EMMETT DEDMON PROFESSOR, HARRIS SCHOOL OF PUBLIC POLICY, UNIVERSITY OF CHICAGO, CHICAGO, IL

Dr. BAICKER. Thank you so much. I would like to thank Senator Warren and Senator Cassidy, and the members of the committee, for the opportunity to talk.

I think there are three topics that I would like to cover to help promote the fiscal sustainability and financial protections that Medicare must provide the beneficiaries, as well as the crucial access to health care. First, I want to talk briefly about payment reforms; second, about patient co-pays and insurance design; and

third, about the benefits and challenges of choice and competition among plans and among providers.

Providers respond to prices much like anyone else. It is not how we usually think about our health-care providers because, of course, they are first and foremost considering their patients well-being. But when we pay more for services, we get more services. And when we pay less for services, we get fewer of them. And right now, Medicare's fee-for-service traditional structure gets the prices wrong despite all best efforts. It is very difficult to write down prices that align with value on a line-by-line basis. And we see over-use of some services at the same time that we see under-use of other services. And that is not the best way to ensure we get the most health care for beneficiaries for every dollar that we spend.

Aligning payments to providers with the value of health care that the service provides could help our dollars go further in promoting health and well-being for beneficiaries. That would include some alternative payment models, each of which has challenges, but which has potential. We see experiments in the Medicare program with alternative payment models like bundled payments, or capitated payments, or ACOs. Those experiments have been on a fairly modest scale to date, so it's not surprising that we have not seen huge changes in response to them.

Some of the experiments in bundled payments, particularly those looking at joint replacement, have seen a reduction in cost while maintaining the quality of outcomes for beneficiaries. But it is hard to write down bundled payment models that incorporate all of Medicare spending. So thus far, they have had pretty limited effects.

It is crucial in thinking about bundled payments as an alternative to the traditional Medicare payments to think about how broad the bundles are. A lot of the savings may accrue from downstream post-acute care versus in-hospital care, or the original surgeon's fees, so it is important to think about broad bundles to promote value and best outcomes for beneficiaries conditional on having that service.

There are alternative models that might incorporate a broader array of Accountable Care Organizations, payment based on global population health for patients in rural populations—and those models aim to share savings with providers so that they can help steer their patients towards the highest-value care, and the care that is right for their individual patients.

Those models, I think, have also shown some promise in helping to align patients' services—and where they get those services—with the best outcomes that they can get for the money spent. The challenge with those models is being assured that the payment rate is right so that you do not incentivize too much care for any given type of payment, nor risk patients not having access to the care they need.

All of these alternative models rely on enlisting providers' expertise in helping to steer their patients, which is vitally important. The doctor-patient relationship is crucial to making sure that patients have the information that they need. I think those provider tools have a lot of potential, but they work even better when you

align patient incentives with getting the care that is right for them, and that is of high value.

I think patient cost sharing gets a bad rap as merely a way to shift costs to patients, but its value as a tool really is much more in helping steer patients toward care that will have the greatest real improvements in health outcomes, and away from care that is of really questionable benefit.

In fact, we know patients, like physicians, respond to the cost of care that is in front of them. When you raise co-payments, patients use less care—not just low-income patients for whom the co-payments would be a barrier, but even high-income patients. They cut back not only on care of questionable health benefit, but also on care that is potentially of high benefit, which is why it is really important that patient cost sharing aligns the co-payments not only with the patient's ability to pay, so that co-payments are lower for lower-income patients, but also with the value of the care so that patients do not risk forgoing care that has high potential health benefits.

Those patient cost-sharing tools can be really important to the effectiveness of getting the provider payments right by aligning all of the incentives with higher-value care that produces better health outcomes. But all of those choices only work when there is a real choice among insurers and among providers. There is a huge return to letting patients choose care that lines up with their own priorities and their own health conditions, and that is not always the case in a lot of parts of the country. So, policies that also promote choices among providers and among insurers can help ensure we spend our health-care dollars wisely.

Thank you.

[The prepared statement of Dr. Baicker appears in the appendix.]

Senator CASSIDY. Thank you, Dr. Baicker.

And now, Mr. Capretta.

STATEMENT OF JAMES C. CAPRETTA, SENIOR FELLOW AND MILTON FRIEDMAN CHAIR, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC

Mr. CAPRETTA. Thank you, Senator, and thank you to Senator Warren also, for holding this hearing, and the rest of the members of the committee. It is obviously a very important topic.

I want to talk about three things. One is how this financing problem for the hospital insurance trust fund fits into a larger picture of fiscal problems for the country. Second, I want to talk a little bit about what I would not do, some ideas that have been advanced to try to address the hospital insurance trust fund that I think should be understood more clearly, and set aside. And then third, some recommendations about broader Medicare reform along the lines of some of the suggestions we have just heard about.

But first, how does this problem fit into the larger picture? The HI trust fund on its own is of course a problem, but really it needs to be understood in the context of Medicare more generally, and the Federal budget overall. In Medicare more generally, it is not well understood that there is a second trust fund, the SMI trust fund, the supplementary medical insurance trust fund, which relies on very large transfers from the general fund of the Treasury to

keep it solvent. And when you look at the totals for that, they are really immense. Over the next 10 years alone, there will be $5.3 trillion transferred from the general fund to SMI to keep it solvent. At enactment, the general fund was only supposed to cover about 50 percent of SMI costs. Now it is up to 75 percent, and it has been for a number of decades, and that is where it stands.

This is not costless. These are taxes that have to be covered one way or another from current taxpayers, or future taxpayers, to pay back borrowing to cover these expenses. The real problem is total Medicare expenses, not HI expenses.

In 1990, total spending on Medicare was 1.9 percent of GDP. Now, it is about 4 percent of GDP. And the Medicare trustees expect it will rise to 5 percent in 2030, and 6 percent in 2050.

Now how does that fit into the larger budget issue? The Federal Government is also borrowing at a huge rate. The Congressional Budget Office projects, because of Medicare, Social Security, and Medicaid spending, that the amount of borrowing is expected to go from roughly 25 percent of GDP in 1980 to about 200 percent of GDP in 2050. So Medicare, along with Social Security and Medicaid—those two programs in particular are very much central to the very massive fiscal problems facing the country. And the HI problem really is just a subset of this much larger challenge that Congress needs to grapple with. And fixing Medicare is central to fixing the larger problem too, so they go hand in hand.

Now what has been suggested to address this problem by the Biden administration, I worry really might end up causing more problems than it would help. What they have suggested, in essence, is to take a current tax, the Net Investment Income Tax that was created as part of the Affordable Care Act in 2010, to pay for the Affordable Care Act's cost. They want to transfer those dollars from the general fund now to the HI trust fund.

That would essentially use the same tax twice. It would be basically using the same revenue to pay for the ACA and then come around later and also pay to keep Medicare HI solvent. I think that double use of the same tax pretty obviously would put the Federal Government in a worse hole compared to the alternative of actually paying for this in a more straightforward manner.

So, what should we do? I think, first of all, we just need to look at this as a broader question and not just related to HI. I am just going to mention five things very quickly that need to be modernized and updated in Medicare.

First, the benefit is too fragmented. It needs to be modernized. It was created as two parts back in 1965 because that was how many insurance plans were designed then, and then a third part, the drugs, was added in 2003. It is time to put this together into one understandable, coordinated benefit with rational cost-sharing. Right now, you have a deductible and a co-payment for hospitalizations, which really does not make sense. So you need to rationalize the benefit structure.

Second, the choice structure—how the beneficiaries go about picking between the plans that they have available to them—needs to be much more clear and seamless and straightforward. There needs to be stronger premium competition between the available

options so that the beneficiaries, when they take a lower-priced option, can save money themselves.

Third, there needs to be price competition among the providers—as Dr. Baicker was just describing—some of it being part of alternative payment models.

And finally, I would just note I would move to a consolidated trust fund. Instead of having these two trust funds, just like the benefit getting combined, I think the trust funds need to be combined into one as well, so that the financing of the whole program could be clearer and handled more straightforwardly across all of the different forms that are available.

Thank you.

[The prepared statement of Mr. Capretta appears in the appendix.]

OPENING STATEMENT OF HON. BILL CASSIDY, A U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Thank you all. I will give my opening statement, and then we will begin questioning.

First, thank you all for joining us. This is a diversity of opinion, and I want to thank my chair for agreeing to hold this. In fact, this is a debate that we should have been having for like 6 years now. And the folks who have been testifying, and those who are watching, know this.

This program goes insolvent in 2026—2026. It is not really "years," it is more like months—it is years, but it is not that many years. And so, thank you all for participating in this conversation. We should be addressing this in a more serious fashion than we are.

My staff wrote this, and I will agree with it, that the challenge of the lack of sustainability and the looming insolvency of the Medicare trust fund are being shrugged off as so disastrous that they will not occur. But I am not sure just ignoring the problem means that it will not occur.

Now frankly, there are some who would wish to expand the benefit beyond that which we have in a program going insolvent in 2026. That does not make sense to me. We have an obligation to the people currently being covered, and yet we would expand the benefit and maybe have insolvency come even quicker. By the way, consequences of insolvency—we all know this, but for the record—under current law, it would be an immediate cut to providers, roughly 20 to 30 percent, which means just as much money coming in would be paid out.

Now, Dr. Baicker mentioned providers are sensitive to costs, to price. I can promise you—I happen to be a doctor, you know—when I am getting paid below my costs, I cannot make it up on volume. And so, if we are paying somebody 20-percent lower than they are currently receiving, which would be below their costs, they will not make it up on volume, which means that this becomes an issue of access for those who are Medicare beneficiaries.

Now, there are over 60 million Medicare beneficiaries in the country. Some would suggest that we do away with cost share. I am a doctor. I can promise you, doctors can prescribe lots of tests. They can prescribe lots of procedures. And there is a lot of data

showing that one thing that puts the brakes on it is if you have just a little bit of cost share—not too much, so the diabetic does not get her needed care—but at least a little bit so people think twice.

It comes to mind, I once had a patient call me, and she said, "Doc, you are my liver doctor—I am a liver doctor—my cardiologist ordered a liver test. I have a health savings account. I will pay for it if I need it. But do I really need it? It is my money." I said, "I am your liver doctor. You do not need it." So, she did not get it.

Contrast that with another patient I had who said, "Oh, I"—she was kind of wealthy—she goes, "I have a bells and whistle policy. I do not care what they charge me because my insurance covers it all."

Now there are consequences of this. My wife, a surgeon, once said, "If you do procedures, inevitably you get complications." And so, when folks are incentivized to over-prescribe whatever it is—drugs, procedures, office visits, et cetera—inevitably there is an associated rate of complications.

So, we have to get—I think Dr. Baicker referred to this; I will use my words, not hers—but this kind of just-right measurement of how much cost share we have, without overburdening the patient, understanding that measure of burdensomeness changes with the individual patient can change.

We need to encourage them to be cost-conscience, to participate in their health care, but not to overwhelm them with the cost, which in turn ends up denying health care.

Now, traditional fee-for-service is a critical source of care, but frankly, many regard it as outdated. It does nothing to incentivize quality and provider improvement parameters, and there is the, quote, "tragedy of the commons" where there is a consumption motivation by both the patient and the physician.

And for the folks who think patients do not demand tests, I can promise you, I have been in the room with patients who have demanded tests which I knew were not necessary. We can quickly make a program that is going insolvent in 2026 go insolvent in 2022, and that is without referring to the motivation that might be among those providing the services.

So this is the state of the program after nearly 60 years of painstaking annual benefit and reimbursement negotiations involving thousands of people here in Washington, bureaucrats if you will, and billions if not trillions of dollars in resources, all the while—a key point made by Mr. Capretta—subjecting beneficiaries to gaps in benefits, and confusing and often hidden costs.

Dr. Kapczynski referred to some of this. We have these kind of mandated—the Federal Government has to pay what is charged sort of things—and then in Medicare Part D we have this way for companies to offload that expense onto the patient. I am a patient advocate. That is wrong. We need to fix that, as we also attempt to address the other financing challenges.

It is time to take a modern approach to the way we deliver health care. Much of that is going to pertain to how we finance health care and an approach that rewards providers for keeping patients out of hospital beds—and one that recognizes the patient and the doctor, and that relationship, as the ultimate arbiter of value, health, and well-being.

We can get there without disrupting the quality and access our constituents need, but the discussion has to begin today.

I thank you all for participating. With that, Madam Chair, I turn back to you.

[The prepared statement of Senator Cassidy appears in the appendix.]

Senator WARREN. Thank you very much, Senator Cassidy. So, let's start with round one questions.

Medicare spends too much money on prescription drugs. The program is barred from negotiating prices, which means that seniors and taxpayers pay way too much just to improve the profits of giant drug companies.

Build Back Better would change this by giving HHS the authority to negotiate the prices of some high-priced brand name drugs. That is not all. It would also penalize manufacturers that raise prices above inflation, and restructure Medicare's drug benefit to make drug companies and insurers do more to cover the costs of prescription drugs.

Now, I am all in for these ideas. These are good ideas. It is really great. The drug pricing provisions of Build Back Better will save an estimated $297 billion. That is a lot of money. But it is not all we can do. We can drive down drug costs in Medicare by enforcing current competition laws. Drug companies use a host of dirty tricks to limit competition, to extend their monopolies, and to keep prices high, and we should put a stop to it.

So, if I can, let me start with you, Professor Kapczynski. Econ 101 tells us that a healthy market is one where lots of companies compete with each other to attract customers, and that that drives prices down.

Does that describe the current state of the pharmaceutical industry?

Ms. KAPCZYNSKI. You know, it really does not—for two reasons, really. One is, as with many other industries, we really have seen a wave of consolidation in recent decades. And this kind of consolidation and concentration in an industry does lead to problems, and it can threaten innovation here as elsewhere.

A colleague of mine here at Yale—Florian Ederer—and colleagues did a study showing that a substantial number of pharmaceutical acquisitions, between 5 and 7 percent, are aimed solely at shutting down innovation that competes with the portfolio of the company purchasing, and those are killer acquisitions, and they affect the development of new drugs.

But there is a broader problem too, and that is, even without traditional kind of industry consolidation, the pharmacy industry has monopoly power baked into it, and that is because of the role of patents and other kinds of exclusive rights that the government grants and that the companies can take advantage of. So they can, as you suggest, expend their energy not on innovating, but on creating thickets of patents around their profitable drugs, delaying generic entry. They can abuse the profits that they get, investing in patent lawyers to pay their competitors to stay out of the market, those pay-for-delay deals. And so, we really do not have a market that functions in a conventional, competitive way. Instead, it is sort of oodles of opportunities to expand and exploit monopoly power.

Senator WARREN. So that is really powerful. Let me just break that apart into both pieces, first about the consolidation in the industry.

As I understand it, between 1995 and 2015, the 60 leading pharmaceutical companies merged into 10. So that is how much concentration there was. Drug companies, we know, are getting bigger and bigger, which stifles competition and elevates prices. But as you say, drug companies do even more to boost their profits. So they game the system to extract as much as they can.

And you mentioned about the patent system already baked into it, and then on top of that there is the abuse of the patent system. So, in a competitive market, we expect to see drug companies' fund new scientific discoveries, get a patent to protect their monopoly for a few years while they earn a rate of return on it that covers their initial expenses, until the time runs out on the patent and competitors can get in and drive down the price of that drug.

That would mean that the vast majority of new drug patents would be issued for new drugs to be brought to the market. That is what a competitive market would look like. And that is how the system was supposed to work.

Professor Kapczynski, is that how the system works? Are new patents more likely to be issued for new drugs coming onto the market, or are they mostly issued for old drugs that are already being sold?

Ms. KAPCZYNSKI. Yes, that is a terrific question. Many people think drugs are patented, and that means there is a patent on the compound. That is really not the case. So drugs are commonly patented with dozens, sometimes even more than 100 patents, and there may be one on the actual medium, but there will be many others, as I said, sometimes dozens, on other kinds of things. In the sort of academic literature, we call these secondary patents. They are patents on things like a formulation, a particular dosage, a tiny alteration in the chemical structure that maybe provides no therapeutic benefit but that allows another patent that you can then use to sue and try to extend the years of life.

So I did a study about this in 2012 with some colleagues, and we found that it is more common for drugs to have patents of these trivial sort of secondary types than it was for them to have compound patents in particular. And in fact, the patents come later, these trivial secondary patents. And so, in the study that we did, these patents could extend patent life for the drug as a whole anywhere from about 6 to 7 years. That is a problem with that kind of evergreening and thickening. These are not therapeutic benefits, and you still get 20 years for those patents. It adds more years of monopoly, and we can see that it happens more with drugs that are more expensive. And when you have drugs that can charge Medicare billions of dollars a year and you add a couple of extra years onto that, of course you get a really serious fiscal problem.

Senator WARREN. So, in other words, the drug companies are racing to protect the profits from their old drugs with more and more patents, not because there is something special about those drugs, but because they want to use the patents—that is, this protected period of time—to stop competitors from being allowed to make them. And the longer they have a total monopoly on the drug, the

longer they can keep prices sky-high and rake in money from the taxpayers through the Medicare program.

So, let me just ask you, Professor Kapczynski, is there any information on how much some of these tactics cost Medicare?

Ms. KAPCZYNSKI. You know, there is. There have been a few studies of this. One found that the drug made by AbbVie called Humira, that delayed generic entry for that one drug cost Medicare over $2 billion between 2016 and 2019.

There was another study that just came out about delayed generic entry of a multiple sclerosis drug, and that cost Medicare up to $6.5 billion in excess spending over 2 years. And as you say, this is a problem because the system incentivizes companies to do trivial innovation instead of really substantial initiatives, costing Medicare billions of dollars.

Senator WARREN. So the two drugs that you mentioned, that is $8.5 billion in excess Medicare spending, just from two drugs.

So I understand that there is another trick that drug companies use, and that is called the pay-for-delay scheme, in which they pay potential competitors not to produce generic versions of the drug because the generic version would undercut prices for their own drugs.

Professor Kapczynski, is there any research on how much these pay-for-delay schemes are costing Medicare?

Ms. KAPCZYNSKI. Yes. There has actually been some research on that as well. And once again, we are talking about billions of dollars. So, Professor Robin Feldman recently did a study that calculated that pay-for-delay deals cost the Federal Government between $2.3 and $13.5 billion, as measured by list prices. So that is a tremendous savings there as well, if we could really curb these attempts to keep generic companies off the market.

Senator WARREN. So that could be $130 billion over 10 years, enough to pay for hearing and vision benefits for all Medicare beneficiaries. So I think of this as, imagine if we put an end to all these tactics and forced drug companies to actually function in a competitive market; we would generate even more savings. And that is not counting the savings that taxpayers could get from Medicare actually being able to negotiate prices.

This is not something special to the pharmaceutical industry. We see in industry after industry, research shows us that monopoly power leads to higher prices. And the pharmaceutical industry is just no exception to that.

We should strengthen enforcement of our Nation's antitrust laws. We should crack down on anticompetitive behaviors that huge drug companies use routinely to keep their prices high. And we should save Medicare billions and billions of dollars as a result.

Thank you.

Ranking Member Cassidy?

Senator CASSIDY. Thank you. Once more, thank you all. It is just an impressive panel.

Dr. Baicker, I sign up my family for insurance. I am a doctor, you know—I have been to med school—and I look at that array of choices, and the complexity of it is like, oh, my gosh, it just takes much longer than it seems it should for me to comprehend this.

Now, you mentioned something which sounds great in theory, but I am not quite sure how it would work. How would we vary the co-insurance or co-pay for an individual based upon her or his ability to pay?

Now, I guess we have a little bit of that with the dual-eligibles, with Medicaid paying for those additional payments. But clearly somebody who is a gazillionaire would have greater tolerance to increased deductibles and co-insurance, and clearly somebody who was a retiree on a fixed income less so. How can we achieve that which is great in theory but would add complexity to a system which is already fairly complex?

Dr. BAICKER. Thank you, Senator Cassidy. That is a great question, because I think you are right. The complexity for patients makes it much harder not only for them to choose, but for them to get any care at all. And on the flip side of that, I think complexity for providers makes it much harder for them to navigate the system, with different patients and different insurance plans. So the implementation of more nuanced cost-sharing for patients would have to be done on the back end in a way that does not inhibit their ability to go in and get care at the point of care.

On the income side, I think we have the infrastructure to make that pretty seamless for patients. You could have, you know, with the lower-income patients, your cost share in tiers could be zero, $5, and $10, for very high-value care, medium-value——

Senator CASSIDY. Let me ask you—let me interrupt. So you are imagining that we would have some sort of immediate access to IRS data on your insurance, or I am sure Senator Warren would suggest we could have some assessment of the person's underlying wealth even if they do not actually report income?

Dr. BAICKER. I think that you could use information available, not in real time, but to think about the year ahead. Are you in a tier of cost-sharing that is low, or medium, or high, based on your reported income, based on your participation in other programs? We have a lot more data. We could harmonize data across the system—and that is a topic for a different hearing—but if we could harmonize data across all of our public programs, we could do a much better job of this.

But I do think that we have the data available to put people into different tiers of cost sharing. That would be relatively easy. The harder part is then deciding which care is of low, medium, or high health benefit. And again, I would not expect providers or patients in real time to assess that item of care for that person, but the data that we now have available through claims data bases, as well as access to electronic health records, gives insurers the opportunity to design a benefit that, in real time, makes things most affordable for patients when that care is of particularly high value——

Senator CASSIDY. Let me stop you there. I was going to ask a pred of this, but you have just stolen the question, if you will. So how do we align that incentive—again, I am speaking of the physician who is in the room with a patient, and they are trying to figure it out. They are already aggravated with preauthorization and the ultimate complexity that the person answering the phone is not aware of for this particular patient. So how do we align the incen-

tives between the patients, the providers, and the payers to get that tradeoff between cost and quality?

Dr. BAICKER. The mechanics of it are no small task, so I would not want to minimize that. And I would be very happy for Jim Capretta to jump in on this, but on the real-time alignment side, right now patient cost-sharing is often operating at odds with incentives that are intended to help providers focus on high-value care. So, imagine that an Accountable Care Organization, or a care manager, is supposed to be thinking about what is the right kind of care for this patient and wants to steer a patient towards a post-acute care to get them home fast—and the resources that also result in better outcomes.

If the patient's cost-sharing is eliminating any kind of financial signal there—as you were saying, patients do pay attention to those signals—if the patient's cost-sharing is completely misaligned with the provider's incentives, any tool you try to deploy on the provider side is going to be much less effective.

We see that in Medigap policies. We see that in Accountable Care Organizations——

Senator CASSIDY. I am out of time, almost. Jim Capretta, in 30 seconds, could you give an addendum to that which was just said?

Mr. CAPRETTA. Well, the only thing I would add is that, as you said in your opening comments, fee-for-service a lot of times can work great, but there is a lot of evidence, and lots of studies that show some management of care—that is, some system that is trying to look across all of the patient's needs for services—does tend to produce higher quality and lower costs.

Now, you have to get the incentive of payment from whoever is enrolling that person into managed care right too. That is either the government or an employer, basically. But managed care can—you know, there is lots of evidence that good managed care, the right kind of managed care, can deliver pretty high value in the right circumstances.

And so I would not discount that as a potential opportunity here.

Senator CASSIDY. So you feel as if that kind of solves the nexus of what I just asked Dr. Baicker?

Mr. CAPRETTA. Mostly, mostly, but not—you know, mostly.

Senator CASSIDY [presiding]. Some of my physician friends are unhappy with that managed care aspect. But we have to move on.

Senator Whitehouse, I believe you are joining us virtually.

Senator WHITEHOUSE. Yes, I am, and I am delighted to be with you. And I will follow up on my friend, Senator Cassidy's, questioning, because we overlap quite a lot on this. I was—I have been a supporter and defender of MedPAC and worked very hard to make sure that CMMI and ACOs got into the original Obamacare bill. And I am kind of an amateur delivery system reform advocate. So that is where I am coming from.

I will send all of you a copy of my handy-dandy favorite graph right here, which shows on the top line the original predicted Federal health-care spend by CBO in 2010 for the 2010 to 2020 decade, and then, tagged onto the end of that, the prediction for 2020 forward.

And then you compare that to the actual. And what happened with the actual is that it came in well below the projections. Even

with COVID surging health-care costs, it came in still well below the projections. And in the next 20 years, the projections are that, compared to the original baseline, we are going to save $6 trillion in Federal health-care spending.

And I contend that that comes from delivery system reform—triple aim—ACOs, getting off of fee-for-service, all the stuff that we have been talking about. And I would like to make sure that we revive that conversation and figure out what we can do to improve ACOs. We have two of the champions both in Rhode Island. One was Coastal Medical and the other was Rhode Island Primary Care Physicians. They are now integrated into larger organizations, but that is how they did the ACO work that made them best-in-show Nationwide, and so those are the names I still think of them by.

But we had really, really, really good results with ACOs. We are trying to get CMMI to go along with the Rhode Island-based sort of mini-Statewide ACO-type thing for advanced care patients, end-of-life care patients, whatever you want to call them, because there are some stupid things that Medicare does with payments, if you are at that point in your life and in your care. We need to free it up so that it is more patient-based also.

So I am really interested in following up this conversation to see what your best recommendations would be to do, you know, ACO 2.0 to see where we should be pushing CMMI. Liz Fowler used to be here in this committee and was Chairman Baucus's lead staffer during the Affordable Care Act proceedings, so she knows this history very, very well, and is very able. So I think we have a big opportunity.

And as to Bill's questions and mine, I think you could basically switch them, other than the Rhode Island State references, and you could not tell who asked them. This is really bipartisan. And even at our bitterest—you know, repeal Obamacare, don't you dare repeal Obamacare, don't you dare—battles, the ACOs, CMMI, delivery system reform, all of that was safe, was unchallenged, was winning and percolating and doing well, and doing well in both red and blue States.

So my purpose in showing up is to enlist all of you in giving advice to this subcommittee as to what we should be doing to push that $6-trillion number to maybe a $7-trillion number, maybe even $10 trillion. But as we have seen over and over again, better health-care decisions save money, in addition to making patients feel better, and generally making doctors feel better about their work. So I think there is a lot of opportunity here, and I would like to ask all of you to pitch in and help us seize the next level of those opportunities.

And if you have specific thoughts, you have 49 seconds.

[Pause.]

Senator WHITEHOUSE. Do you agree that this is a good place to go, at least?

Senator CASSIDY. Sheldon, can I interject for a second? Because Sheldon and I have talked about this a lot. And I was going to follow up with a question, if Senator Daines allows me a minute more.

Senator Whitehouse is pointing out that in the case of Medicare Advantage, it is anchored to an unenrolled cohort. So the MA plan

can improve, but it still makes a profit because it is anchored to an unenrolled cohort.

So, Dr. Chernew, this may be a question for you. Whereas ACOs, the more they save, the less margin there is to save, and so therefore their upside becomes less and less. If you will, it disincentivizes further improvement. So I think, Sheldon, that is what I gathered your concern is.

Senator WHITEHOUSE. We had some jolly wars with the Obama administration about punishing rather than feeding the lead dogs, and basically trying to get them into a situation in which no further gains could be extracted. And even if they were way more efficient than their next-door physician groups, they were punished for that. So there were some very unfortunate decisions that were attempted to be made during the Obama administration, but I think we fended off the worst of them, and it all actually turned out pretty well, though there was a lot of hard work for the ACOs to plow through.

Senator CASSIDY. So, Dr. Chernew, is there a way, as Sheldon presented the problem, as I kind of elaborated on in my interpretation of it, is there a way to address the fact of a diminishing return for the greater quality you get?

Dr. CHERNEW. So first, thank both of you for your question. Actually, I enjoyed listening to your discourse. Let me start by saying that it is pretty well acknowledged that there is inefficient care delivery in the fee-for-service system, and that the fee-for-service payment model is not well-suited to get rid of a lot of that inefficiency. And I think, as you both were discussing, the ACO program offers some promise. MedPAC in general has been very supportive of this direction of payment reform, and we have been actually having discussions about exactly how to solve that problem with benchmarking. We call it the ratchet effect. The better you do, the less you get paid in the future. And we will be having a report published in June to address that specific issue. The sort of foreshadowing of results is, yes, I do believe there are ways in the regulations that you could address that problem. More broadly speaking, payment reform is particularly important. The trick is to get the regulations right to provide the incentives for efficient delivery of care and maintaining quality care. What we have seen so far, I think, has been success of alternative payment models, but honestly, not a ton of success. And through, I believe, appropriate changes to regulations as MedPAC is now discussing, we can do a lot better and make sure that the way in which we pay providers is not an impediment to the efficient delivery of care that we need, if we are going to maintain fiscal sustainability and manage it properly.

Senator WHITEHOUSE. Okay. So my favorite illustration of this is, we have an insurance company in Rhode Island, a neighborhood health plan, that deals with a lot of the lower-income population, Medicaid and so forth, and a new CEO came in and he went through all their frequent flyers at the emergency departments, and he sent social workers to go talk to all of them.

And one social worker came back and said, "Hey, boss, I think if we buy this guy an air conditioner and a TV, we can probably reduce his appearances in the emergency department quite a lot.

He is running about, you know, $230,000 a year now, because he has a few conditions, and when he goes in, they find something, and they have to deal with it, and around and around you go. But he seems to be going just because he is hot in the summer and lonely." So, yes, here is a couple of hundred bucks, go to Walmart and get an air conditioner, get a TV. And sure enough, he went from—I am making up the numbers now, but, you know—20 emergency department visits to 2. And they saved hundreds of thousands of dollars.

Now it is really hard to create air conditioners and televisions as a benefit. It is really inefficient to do that. But if you let people who know the patient make some choices like that, and you allow the cost—you know, if the social worker had to buy the TV and the air conditioner herself, that would be pretty expensive——

Senator CASSIDY. Okay, Sheldon, I have to move on to Senator Daines.

Senator WHITEHOUSE. Okay; that is just one way to improve——

Senator CASSIDY. Okay.

Senator Daines?

Senator DAINES. Dr. Cassidy, thank you. And thank you for holding this hearing. I was also enjoying the back-and-forth.

There is no question that Medicare provides critical support to seniors and people with disabilities in my home State of Montana. Tens of millions of Americans rely on this program. It is bringing access to affordable medical care. And, unfortunately, the major changes in demographics and rising health costs have placed this program on an unsustainable path. I think that is why we are here today.

The numbers that I just looked at yesterday are very concerning. Looking back at 2020, Medicare spent $925 billion on medical services for American seniors, but the program collected less than half of that amount in payroll taxes and monthly premiums. So, if you look at where the rest of the cost is covered, about $400 billion is picked up by the Federal taxpayer. This taxpayer-funded amount is going to grow every year.

It is troubling news, as we saw what just came out in the last 24 hours: our Federal debt just hit $30 trillion for the very first time. To make matters even worse, the hospital insurance trust fund, which pays for seniors' hospital bills and other services—its depletion is projected now to be in 2026. That seemed like a long time in the future years ago, but it seems very close today. We may need to come together to save and strengthen Medicare for my generation, and of course for those to follow.

Ten years ago, the chairman of this committee, and the House Budget Committee chairman Paul Ryan, unveiled a proposal to reform Medicare—10 years ago. It seems like just a few years ago, but it was 10 years ago. It was a major effort to recognize the need for structural reforms to ensure Medicare's solvency.

The Ryan-Wyden plan was designed to protect the program, lower costs for consumers, and help control costs through competition and choice, all without cutting benefits. At the end of the day, reaching a bipartisan consensus on modernizing Medicare through such structural reforms, alongside prescription drug reforms and delivery of care reforms, is going to be critical in ensuring that

Medicare remains a guaranteed option for seniors in my home State of Montana and across the country.

Going back to the Clinton Medicare Commission's recommendations in 1999, 23 years ago, there have been numerous bipartisan proposals to improve the solvency of Medicare and protect it for our Nation's seniors.

My question, Mr. Capretta: could you elaborate, if you were to pick one, two, or three reforms you would want to recommend to this committee to pursue, what might they be?

Mr. CAPRETTA. Well, the first one I would start with is the one you just described, which is essentially—I think some people disparage it a little bit with this term—but it is called premium support, which is the Congressional Budget Office's model. In my written testimony, I describe how that would work.

Basically, it would be to, in a very standardized way—getting back to Senator Cassidy's point earlier about confusing choices, you have to present to the beneficiary the very clear standardized options for both the traditional coverage in Medicare, for their D coverage for drugs, and for supplemental benefits. All that needs to be standardized so they can identify very clearly that the premium differences between the options are strictly based on efficiency of care delivery and not differences in benefits.

So you have to standardize what they are looking at, and then bring competition into it, so to say, if they pick a lower-priced option, they get to save some of the premium themselves. That is the essence of premium support.

And the Congressional Budget Office has estimated that it would save about 8 percent relative to current law spending. And the beneficiaries would save about 5 percent, if you based the contribution toward the coverage at the average premium.

So I think there is a lot of promise there. It is controversial in some ways. It has been done on a bipartisan basis periodically. I do not think it needs to be controversial, because these choices are already there. There is already some level of competition. It is a way of organizing it better so it is more clear what the competition is aimed at, and that is, cutting premiums for the beneficiaries.

Senator DAINES. So that is a great recommendation. I have 30 seconds here. If you were to give us your second round draft pick, what might it be?

Mr. CAPRETTA. I think there should be more provider competition along the same lines, that is, even for those in fee-for-service. If they select a practitioner who is going to charge less for a service, I think we ought to let the beneficiaries save some of their money, regardless of where they are in the cost-sharing scheme or the deductible. In other words, get more price transparency going. Get more bundled pricing going. And then, when the beneficiary picks that hip replacement surgery that is less expensive, why not let them keep some of the savings too, regardless of where they are in their deductible?

I think if you want competition on pricing and to get revealed pricing that is more relevant than just regulated pricing, those are the kinds of ideas you have to pursue.

Senator DAINES. Thank you. And one of the words I have heard a few times tossed around here, and I believe it is always part of

the solution, is the word "incentive." Incentivizing better outcomes, lower costs. I think we will see, at the end of the day, it is going to be an important part of what we do here to change the system to save this important safety net.

Thank you.

Senator WARREN. Thank you, Senator Daines.

So, we were talking earlier about drug companies, but they are not the only ones who have figured out how to game the rules and drive up costs. A few decades ago, Congress started letting private insurance companies administer Medicare for seniors who opted in. The insurance companies claimed—when they were first getting permission to do this—that they would run Medicare better than the Federal Government. More benefits at less cost; that was the promise.

But over the past 12 years, Medicare Advantage, the part of Medicare where insurance companies have the biggest role, has actually cost the Federal Government $143 billion more than traditional Medicare. Meanwhile, insurance companies have soaked up literally billions and billions of dollars in profits from undertaking this.

Now, one serious problem is how Medicare pays insurance companies. So let's imagine a specific patient who goes to the doctor for her heart murmur. It turns out that this patient had shoulder surgery a few years ago. She also has exercise-induced asthma.

Dr. Chernew, would the patient's surgical history or her asthma diagnosis affect how her doctor gets paid for this visit in traditional Medicare, if she is covered by traditional Medicare?

Dr. CHERNEW. No. In fee-for-service——

Senator WARREN. Dr. Chernew?

Dr. CHERNEW. I am here.

Senator WARREN. There you go. Go ahead.

Dr. CHERNEW. Sorry. No, in fee-for-service, physicians get paid for the visit and related tests and services that they provide, which in this case would likely be limited to the patient's heart murmur or whatever conditions they went in for, not a bunch of conditions that happened in the past that they were not being treated for at the time of the visit.

Senator WARREN. Okay, so let's keep building on this. In traditional Medicare, doctors are paid for the services they provide. For this patient, if her doctor does not need to take an X-ray of her shoulder, or prescribe her a new inhaler for her asthma, then those diagnoses may not even appear on her record. That could mean that doctors in traditional Medicare under-report diagnoses, but Medicare Advantage has the opposite problem.

Dr. Chernew, how would discovering those additional two diagnoses change the way that Medicare pays Medicare Advantage for patient care?

Dr. CHERNEW. Sure. So because Medicare Advantage gets paid more for patients who have more diagnoses—at least in the following year they get paid more—they would generally get paid more if they are able to record more diagnoses.

If I could, let me illustrate with a slightly different example, which is the work of a colleague of mine, which suggests that for every 100 patients in fee-for-service with congestive heart failure,

only about 75 percent have reported congestive heart failure in the following year. Because Medicare Advantage plans have the financial incentives, they devote resources to identifying those patients. And by adding that code, the plans therefore get paid more from identifying undiagnosed congestive heart failure, or preventing previously diagnosed congestive heart failure from dropping off in subsequent years. And that leads to higher Medicare Advantage payments, because the risk adjustment system, as you pointed out, is poorly calibrated.

Senator WARREN. Okay. So this risk adjustment means that payments are going to go up. And I guess the underlying logic is that a sicker person is going to use more health-care services, so Medicare is going to compensate for the additional risk. But I take it that what you are saying, Dr. Chernew, is that having a higher risk score in Medicare Advantage does not necessarily mean that the patient is either going to get more care or better care. Is that what you are saying here?

Dr. CHERNEW. They might not necessarily get more or better care, or they might. It is a calibration issue. But, yes, you are correct. Those added codes may not actually be treated. That is true.

Senator WARREN. Okay. And Medicare Advantage plans, they are not finding new diagnoses so they can help people get more care; they are doing it so they can make more money from Medicare, because that is how the system is set up.

In fact, an entire industry has been created to help them do exactly that. And as a result, Medicare ends up paying more for a beneficiary's care in Medicare Advantage than it would pay for exactly that same beneficiary's care in traditional Medicare.

So, Dr. Chernew, you have studied this for a long time. If the Federal Government cracked down on these insurance company practices, how much money would it save Medicare?

Dr. CHERNEW. So the Medicare program already takes some money out to adjust for this miscalibration. The Commission believes that that's insufficient. And so, if you took out another 3 to 4 percentage points, for example, which is our estimate of the added payment, in 2021 you would have saved about $10 billion.

Senator WARREN. Wow. And you know, I actually—we were looking into this, my team and I. It turns out that other experts have even put the number higher. Some say as high as $600 billion over the next 8 years.

Think about it. That one change alone creates more money than the hospital insurance trust fund's entire projected shortfall through 2031. And that isn't even the only scam that Medicare Advantage plans use.

We could save almost $200 billion more by eliminating some of the other tricks that Medicare Advantage plans use to squeeze money out of Medicare. That would be enough to make a down payment on lowering the Medicare eligibility age, or adding dental benefits to Medicare.

Insurance companies have promised more competition and lower costs for decades. But instead, they have cost the Medicare program billions of dollars. And that is because the goal of giant insurance companies is not to save the government money; the goal is for the insurance companies to make profits for themselves. And

more often than not, they do that by ripping off the Federal Government and denying people the care that they need. I think it is time for Congress to put an end to this kind of corporate profiteering.

So ordinarily, at this point I would hand the questions back over to Senator Cassidy, but we are trying to manage votes at the same time. So Senator Cassidy is not here. So I am going to turn around and go to another round of questions. I am not going to let you all waste any time at all.

So here is where I would like to start on this one. And that is, in 2019 the Trump administration announced a new Center for Medicare and Medicaid Innovation, CMMI, initiative to allow private plans to use the same scams that they perfected over in Medicare Advantage and import those into traditional Medicare, once again driving up costs for taxpayers.

Now, under CMMI's Direct Contracting model, Medicare beneficiaries will be assigned to a Direct Contracting Entity. We heard about this earlier in direct testimony here. These are called DCEs. And like the insurance companies in Medicare Advantage, DCEs will receive a fixed payment to cover the beneficiary's care. But then they get to pocket virtually all of the money that they do not spend on patient care.

This has set off a global gold rush on Wall Street. Beneficiaries are enrolled in DCEs based on their primary care provider, so insurance companies, private equity firms, and institutional investors are scooping up primary care practices so that they can get in on the deal. And these investor-owned doctor practices use the same playbook as Medicare Advantage to squeeze more money out of Medicare.

Dr. Rogers, you spoke about this. You have studied this. Of the 53 Direct Contracting Entities that CMMI has already approved, how many are owned by private investors and insurance companies, as opposed to hospitals, doctors, and other health-care providers?

Dr. ROGERS. Thank you, Senator Warren, for this question. There are 28 DCEs that are investor-owned, and there are 6 that are owned by Medicare Advantage insurers. So these are the ones that are there for the profit. And to me, there is clearly a conflict of interest if you are there to provide health care, but your mission is to make money.

It is a conflict of interest, and it is not going to ever be equal. And unfortunately, the people who are going to lose are patients. Denial of care is the way they will control costs. They will limit access, employ preauthorization—there are a lot of mechanisms that are there.

One of the things that has been done too—and we talked about the up-coding and how patients are made to look sicker. It is embedded in the software. So, as a physician, I cannot sign off on a chart until I have checked enough boxes so that they can up-code.

Senator WARREN. Wow.

Dr. ROGERS. It is part of the infrastructure now, so even though that is not what I want to diagnose them with as their provider or their physician, it is embedded there in the structure.

Senator WARREN. And this is by design. I mean, what you are talking about when you say it is embedded in the structure—the majority of these DCEs are investor-owned. And CMS has said that one of its goals for the Direct Contracting model is to bring in organizations, and I'm going to quote them here, "that currently operate exclusively in the Medicare Advantage program," to bring that into traditional Medicare. And to make the deal even more attractive for these private actors, CMMI has weakened key guard rails that will allow insurers and investors to pocket even more profits through the Direct Contracting model than they can now do in Medicare Advantage.

So let me ask another question around this. Under Medicare Advantage, plans are legally required to spend at least 85 percent of their revenues on patient care. Essentially, it sets a 15-percent cap on total profits.

So, Dr. Rogers, does the same cap exist in DCE programs?

Dr. ROGERS. Well, it is a very much smaller cap, I can tell you that, because the DCEs only have to be—they can keep up to 60 percent.

Senator WARREN. That's right. So in other words, they can make 40 percent in profits.

Dr. ROGERS. They need to spend 60 percent. I had that backwards. They need to spend 60 percent. But they are able to take 40 percent. So that's—I mean, when we talk about trying to control costs, they are not adding anything to care. These are investors. They know nothing about health-care delivery. These are investors who are making money. And to me, I think health care should be off the buffet table when investors come in and decide what they want to put on their plates.

Senator WARREN. I want to say on this, I support coordinated care, and I appreciate the potential that coordinated care models have to lower costs and improve the quality of care. But give me a break on what's happening here.

Wall Street is not racing to buy up clinics because they want to expand coordinated care models and limit profits. Private-equity insurance companies want the eye-popping profits that are possible when the Federal Government lets them pocket whatever it is they can avoid spending on seniors and people with disabilities who need health care.

So, Dr. Rogers, right now, as you know, we are in the demonstration project phase on this. If this demonstration project is allowed to proceed, does it effectively amount to a privatization of Medicare?

Dr. ROGERS. Totally. Totally. If you look at our health-care system now, Medicaid is very much privatized. Private insurance is privatized. And then the other big one is Medicare, which is becoming privatized. And by "privatized," I mean public monies are going into an entity and giving total control of those dollars to that entity. That is complete privatization.

Senator WARREN. So privatization—and let me just ask: over the 35-year history of Medicare managed care, including Medicare Advantage, have these private-sector arrangements ever delivered the cost savings that taxpayers were promised when the plan started?

Dr. ROGERS. Never. Never. Never. They have been paid billions, and in fact the managed care companies have been paid hundreds of billions more than if people had been in traditional Medicare.

Remember, traditional Medicare has an overhead of 2 percent. There is nobody working in DC and in CMS who is making millions of dollars a year as their salary. So you have a whole different system in the private system, and that is where all the money is going. And even if we look 8 years ahead, because CMMI, they want to move everybody enrolled in traditional Medicare to the DCEs. And by 2030, that will cost us more than $600 billion.

We forgot about providing care. I mean, this is—you know, it is all about making money.

Senator WARREN. Thank you, Dr. Rogers.

It is completely baffling to me that the Biden administration wants to give the same bad actors in Medicare Advantage free rein in traditional Medicare. Without intervention, the 53 existing DCEs will enroll as many as 30 million of the 36 million beneficiaries who are now in traditional Medicare. That means that 80 percent of traditional Medicare will be privatized. And the new owners of Medicare will use the same scams they have been using for years in Medicare Advantage to drive up the costs of traditional Medicare.

My view is that President Biden should not permit Medicare to be handed over to corporate profiteers. Doing so is going to increase costs and put more strain on the hospital insurance trust fund. The Biden administration should shut down the Direct Contracting model immediately.

And I see that Senator Cassidy is back, and Senator Cassidy is recognized.

Senator CASSIDY. Dr. Kapczynski—I apologize; I keep on mangling your name—I apologize, but I am sure I am not the first person——

Dr. KAPCZYNSKI. Not at all. [Laughter.]

Senator CASSIDY. You know, you raised an interesting issue of Humira as an originator drug, and yet it really should be replaced with a lower-cost option, but it is not. We are paying a lot of money for that.

Now, one thought that has been raised to encourage patients to convert to a follow-on biologic similar, a follow-on drug, would be to gain-share. If there is a price here for the originator drug, and a price here for the biosimilar, you would gain-share both the physician and the patient so that they would share in the savings that accrue. And the idea is that that is a way to motivate people. What thoughts do you have about that?

Dr. KAPCZYNSKI. So I think it can be helpful to encourage substitution of generics and biosimilars where we do not have any difference in the drugs. We just know that we have new entrants on the market, and sometimes they have brand recognition, things like that, that otherwise are kind of a barrier to patients getting more affordable drugs.

So I do think that that is something that we should be thinking about. That said, I think that the way that the patent system works, sometimes we do not even have competitors on the market.

Senator CASSIDY. I am totally with you on the patent thickets. I am with you on that. But let me just kind of continue on this line of thought.

Mr. Capretta, MA plans, if you will, somewhat gain-share with patients by adding different benefits—the health club benefit, for example—and lowering premiums. But as far as I know, there is no gain-share in which there is cash deposited into an account which they could use to make their own decisions.

I say that because I think Dr. Chernew's testimony spoke about how some of the benefits of the MA plans are not really used by the beneficiaries as much. But if they had their own fund which they could use—for example, to pay for over-the-counter drugs—that might be more meaningful to them.

If we take the same sort of concept, the gain-sharing, as a way to reward patients and providers for making better decisions, what do you think about applying that to Medicare?

Mr. CAPRETTA. I completely support that. I would note that MA plans are allowed under current law to rebate against the Part B premium, and so there is the opportunity for that to some degree.

But I have to say, there have been many studies of this. And most MA plans don't go that direction. They go down to a zero premium. And if they could offer a rebate, they instead offer supplemental benefits, much of which are very difficult for the beneficiary to quantify and translate into their value in a premium. Maybe that is what you are getting at in terms of what Michael said.

So I think we need to make these choices more transparent for the beneficiary when they actually have an opportunity to make a choice, so that when they pick the MA plan, they can save money in the premium with an apples-to-apples comparison with traditional Medicare. And then also, as you indicate, when they are using the individual services, we should work with the MA plans through the regulatory structure to say you should be allowing them to save money too, when they pick lower-priced providers, even below what you have negotiated with them.

So you know, we need to get some more transparency going in the pricing of the premiums, and also in the pricing of the individual services, and of course drugs and devices as well.

Senator CASSIDY. Dr. Baicker, I used the example from the private insurance market of the health savings account, and I gave the example of the patient calling me, and you are my liver doctor, and all of that. And so the fact that she was spending her own money really motivated her to get in touch with me and to make a wise decision. Kind of that nexus you are describing about cost and quality.

Now just a thought experiment. I'm just kind of—this is stimulating—this conversation has stimulated this thought. If you are able to gain-share with the patient so that maybe some benefits which she may not think are important to her would be replaced by an account which could only be spent upon health care; again, imagine a dental service without having dental insurance, or being able to pay for the over-the-counter drug. Is there sufficient data that we could intuit that that would help us solve this kind of conversation between the provider and the patient regarding necessity

and quality, understanding that, to an extent, the patient would be the payer?

Dr. BAICKER. I think we have evidence that value-based insurance design, where patients are paying based on their ability to pay, but also on the value of the service, can actually result in better effectiveness and better health outcomes. But it has to be based on good information, and also based on the providers knowing what the patient needs for the next step in care. And that is not the way the system works right now. But patients having more stake in it would help make the provider-side incentives more effective and would help give the patients more choice. And there is a lot of evidence as well that patients have very different preferences. If you ask people about their priorities, some people would really like to have lower co-payments and a more restrictive network. Some people would rather have more expansive networks and higher premiums. But there is some return to that choice for that patient in making sure the dollars are spent where they are valued the most.

There is also system-level benefit and spillover through creating efficiency in health. When incentives lead to some patients being treated more effectively, that can benefit others who need similar treatment, or other patients who are seen by that set of providers or in that hospital system.

Senator CASSIDY. So you are still emphasizing, rightly I think, the role to have the systems' approach to how the patient is managed, but at the same time, accepting that part of that could have the patient have this model where she saves a little money if she chooses a less expensive option. But the physician has to be held accountable to make sure that it is still high-value care, not just cheaper for the sake of being cheaper. Am I summarizing well enough?

Dr. BAICKER. Absolutely. The patient has to reap benefits in terms of more affordable care, and care that better matches her preferences. The provider has to reap benefits in order to allocate resources to the places that have the highest value for the system to reap benefits.

Senator CASSIDY. And one thing—and my chair has been very tolerant of my going over. Way back when I reviewed the literature, and it has been a while, the concept of an engaged patient, I just happen to know, again from my practice, whatever the economic circumstances of my patient—and I worked in a hospital for the uninsured—if she or he was engaged, and you could measure engagement, the outcomes were better. They were more likely to adhere to their insulin. I am sure Dr. Rogers would agree with this. They were more likely to take their blood pressure medicine, if they were engaged. And one thing that I know the literature points out is, engagement is also enhanced by the patient having some sort of financial buy-in, if you will.

And that comes in a variety of forms, but the health savings account is a classic one, as I spoke of in my example of a patient, that if she has a little bit of dollars that she has to spend, then she is going to scrutinize more carefully. Do I remember that literature correctly?

Dr. BAICKER. Yes. I think there is a big behavioral economics literature pointing to the importance of patient engagement and how

these tools can help. And patient incentives do not need to be just in the form of higher co-payments; they could also be rebates to patients to achieve lower costs and more effective patient care. And there is some evidence that sending patients checks in the mail is another powerful way to engage their thoughts about where care is really valuable.

Senator CASSIDY. So I will finish with this. Your last statements suggest that you agree with Dr. Kapczynski that if we manage to gain-share with the patients and choose a follow-on biologic, as opposed to an originator drug, that would be a way to move behavior while maintaining quality of care. So I think we went far from that original point, but I think we ended up there as well.

Madam Chair?

Senator WARREN. Thank you, Senator Cassidy.

And I ask for unanimous consent for Senator Burr to be able to submit a statement for the record. Hearing no objection, so ordered.

[The prepared statement of Senator Burr appears in the appendix.]

Senator WARREN. I want to thank Senator Cassidy for being a great partner in the two of us putting together this hearing today. It has been enormously valuable. We covered a lot of topics, and I think we covered them with some data and some clarity, and I appreciate that.

I want to thank our witnesses. I really appreciate your being here.

For Senators who wish to submit questions for the record, those questions are due 1 week from today. That is Wednesday, February 9th. And for our witnesses, you will have 45 days to respond to any questions. And again, thank you very much for the work that you have done in this field, all of you, for a very long time. And thank you for being with us today.

And with that, this hearing is adjourned.

[Whereupon, at 4:09 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF KATHERINE BAICKER, PH.D., DEAN AND EMMETT DEDMON PROFESSOR, HARRIS SCHOOL OF PUBLIC POLICY, UNIVERSITY OF CHICAGO

SUSTAINABILITY AND VALUE IN THE MEDICARE PROGRAM

My name is Katherine Baicker, and I am dean of the Harris School of Public Policy at the University of Chicago and a health economics researcher. I would like to thank Senator Warren, Senator Cassidy, and the distinguished members of the committee for giving me the opportunity to speak today about sustainability and value in the Medicare program. I serve on a number of boards and advisory panels, but am presenting my own views. This statement draws on several pieces I have written in this area, as well as research conducted by many others.

The importance of access to health care and the financial protections that insurance should provide have never been more salient, and Medicare is a vital part of our health-care system for millions. Ensuring that Medicare maximizes health benefits within a financially sustainable system requires careful attention to insurance design and balancing tradeoffs across multiple dimensions of coverage and payment structure.

Payment Models to Promote Value

Moving towards models of paying for value, rather than volume, is a crucial step in ensuring that health-care resources are well spent. As Michael Chernew and I have written,[1] there are promising strategies for improving quality and reducing ineffective spending that rely on reforming the way we pay for health care to align providers' incentives to improve value. Providers' judgment is crucial in finding ways to reduce waste and help patients chose the most efficient sites and types of care based on their health-care needs. Giving providers a financial stake in driving value can be much more effective than reforms that focus solely on patients' incentives or rely on inflexible government coverage rules.

There have been a number of experiments with promising mechanisms, but these have been implemented in limited ways and with limited financial consequences—and thus with limited effects. Some payment models focus on episodes of care, using bundled payments to incentivize providers to limit spending during the episode while achieving quality benchmarks. The savings usually accrue to the hospital or specialist responsible for the episode. Evidence on the effectiveness of such models is mixed. Some studies suggest that bundled payments for joint replacement may reduce spending—both for the patients covered by that payment model and for others treated by the same providers.[2, 3] Much of the savings may derive from reductions in post- acute care utilization, highlighting the importance of how broadly bun-

---

[1] Baicker, Katherine and Michael Chernew, "Alternative Alternative Payment Models," *JAMA Internal Medicine* 177, no. 2 (2017 February 1): 222–223.

[2] Finkelstein, Amy, Einav, Liran, Ji, Yunan, and Mahoney, Neale, "Randomized Trial Shows Healthcare Payment Reform Has Equal-Sized Spillover Effects on Patients Not Targeted By Reform," *PNAS* 117, no. 32 (2020 August 11): 18939–18947.

[3] Finkelstein, Amy, Ji, Yunan, Mahoney, Neale, and Skinner, Jonathan, "Mandatory Medicare Bundled Payment Program for Lower Extremity Joint Replacement and Discharge to Institutional Postacute Care Interim Analysis of the First Year of a 5-Year Randomized Trial," *JAMA* 320, no. 9 (2018): 892–900.

dles are defined.[4] Other studies find much smaller changes in spending.[5] Attention needs to be paid to incentives to select healthier patients or shift costs of care downstream, as well as to the "extensive margin" of the number of bundles, not just the "intensive margin" of the cost per bundle—the risk of offsetting volume increases. Furthermore, bundled payments as currently constructed cover only a small fraction of Medicare spending, and savings to date have been driven by a small subset of episode types.[6, 7]

Other approaches focus on total population spending, such as Accountable Care Organizations. These models provide incentives for provider groups to reduce per-capita spending and improve quality. The savings generally accrue to the organization that employs the primary care provider. Population-based payments have the potential to cover a greater share of spending and thereby have a bigger impact system-wide, although savings to date have been modest.[8]

It is important to note that the Medicare program doesn't capture all of the savings in either model—a large share of savings are "shared" with providers. Potential savings to the Medicare program depend on how the benchmark payments are set. In the episode-based models, benchmarks are often set a bit below estimated spending, guaranteeing that Medicare will reap some savings, but any greater savings would go to providers. The share of savings providers get to keep—and their risk of loss—drives the incentives to improve efficiency. Over time, savings to Medicare could grow if benchmarks rose more slowly than they otherwise would. As discussed below, Medicare Advantage is an increasingly attractive option for beneficiaries, giving beneficiaries a choice among private plans that often come with expanded benefits, more active management, and limitations on provider networks. None of these alternatives seems to lower the quality of care, but both payment structure and risk adjustment should be constructed with an eye to promoting quality and access.[9, 10, 11]

Alternative coverage and payment models could thus be substantial improvements over the fee-for-service system that dominates Medicare now, but the effectiveness of these tools will depend on having broad scope and real financial stakes; and the way that payments are calibrated will drive the share of any savings that accrues to the Medicare program (taxpayers), providers, and patients.

Patient Choices and Financial Protection

Another driver of access, utilization, and value is the set of cost-sharing and coverage parameters faced by patients—what services are covered, which providers are included, and how much patients are expected to pay out-of-pocket. Patient cost-sharing is often perceived as merely a mechanism to shift costs to patients that results in restricted access to needed care, but more nuanced use of patient cost-sharing can be a powerful way to promote better use of health-care resources without creating barriers to needed care.[12]

The traditional economics model is based on patients having detailed information about the value of care options and the ability to implement choices that fully incor-

---

[4] Navathe, A.S., Troxel, A.B., Liao, J.M., et al., "Cost of Joint Replacement Using Bundled Payment Models," *JAMA Internal Medicine* 177, no. 2 (2017): 214–222.

[5] Dummit, L.A., Kahvecioglu, D., Marrufo, G., et al., "Association Between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes," *JAMA* 316, no. 12 (2016): 1267–1278.

[6] Urdapilleta, O., Weinberg, D., Pedersen, S., Kim, G., Cannon-Jones, S., Woodward, J., "Evaluation of the Medicare Acute Care Episode (ACE) Demonstration: Final Evaluation Report," (2013): *http://downloads.cms.gov/files/cmmi/ACE-EvaluationReport-Final-5-2-14.pdf.*

[7] Dummit, L., Marrufo, J., Marshall, J., et al., "The Bundled Payments for Care Improvement Initiative Models 2–4: Year 2 Evaluation and Monitoring Report," (2016): *https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf.*

[8] McWilliams, J.M., "Savings From ACOs—Building on Early Success," *Annals of Internal Medicine* (2016): *http://annals.org/aim/article/2566329/savings-from-acos-building-early-success.*

[9] McWilliams, J. Michael, Hatfield, Laura, Chernew, Michael., et al., "Early Performance of Accountable Care Organizations in Medicare," *New England Journal of Medicine* 374 (2016): 2357–2366.

[10] Baicker, Katherine and Jacob Robbins, "Medicare Payment Policy and System-Level Health-Care Use: The Spillover Effects of Medicare Managed Care," *American Journal of Health Economics* 1, no. 4 (2015 Fall): 399–431.

[11] Baicker, Katherine, Chernew, Michael, and Robbins, Jacob, "The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization," *Journal of Health Economics* 32, no. 6 (2013 December): 1289–1300.

[12] Baicker, Katherine, "Rethinking Health Insurance Design," *JAMA Health Forum* 2, no. 5 (2021 May 13): e211440.

porate their preferences and priorities. Health insurance protects patients against the financial risk of needing expensive care,[13] but it also generates use of care that is of lower value by insulating patients from having to pay the true cost of care (which they would only do if it was worth it to them in terms of improved health)—described as "moral hazard" by economists. There is ample evidence that higher copayments do reduce the use of health care.[14, 15] Patient cost-sharing would ideally balance the positive effect of risk protection and the negative effect of excess use. In this simple world, if a $10 copay deters use of a service, that indicates that the patient valued the health benefit of the service at less than $10—with the copayment thus deterring use of low-value care with little health benefit. Copayments should be highest for care where patients are most price- sensitive, since that is the care of least value to them. Higher copayments wouldn't increase patients' total costs in this simple case, since health insurance premiums would be commensurately lower.

But, of course, that simple model does not capture the complex reality of the difficult choices patients have to make, often in fraught circumstances, under time pressure, and with incomplete information. There is strong evidence from behavioral economics, medicine, and psychology that higher copayments reduce use of high-value as well as low-value care. This is of particular importance for low-income patients, but is also seen in higher income populations for whom the copay is not unaffordable. The health costs of reductions in care in response to even modest copays, which we've called "behavioral hazard," can be severe, reflecting the real-world limitations in decision-making that all patients face, such as limited information, limited time, challenges in follow-through, and misperceptions of risk.[16, 17]

These findings can inform the design of nuanced cost-sharing that is a positive force for higher value care.[18] Copays could be higher for care that is of questionable health benefit, and lower (sometimes free, or even negative) for care that is of high health benefit. Such insurance design could simultaneously improve the important financial protection that health insurance offers for enrollees and substantially improve health outcomes.[19] While such insurance design improvements would not necessarily generate savings for the Medicare program itself, they could amplify the effectiveness of provider payment reforms, indirectly benefiting the program's finances as well as enrollees. Reforms to Medigap in particular could be helpful in this regard.

Competition to Foster Innovation, Affordability, and Value

Competition among insurance plans can be a powerful driver of innovation that both improves health outcomes and reduces prices. The Medicare Advantage program provides an example of giving enrollees a choice among publicly funded insurance options.

One advantage of having multiple plans available is that different enrollees have different preferences and priorities—both for the total share of resources they would like devoted to health care and for the types of features in health insurance that they value the most, such as tradeoffs between lower copayments, more expansive networks, lower premiums, and more comprehensive coverage.[20] Since Medicare's inception, health care has gotten much more complex and expensive, income disparities have widened, and the cost to taxpayers has increased dramatically.[21] Adding flexibility along multiple dimensions—along with subsidies to ensure that robust insurance is affordable across the income distribution—can leave everyone better off.

---

[13] Baicker, Katherine and Levy, Helen, "Cost Sharing as a Tool to Drive Higher-Value Care," *JAMA Internal Medicine* 175, no. 3 (2015 March): 399–400.

[14] Newhouse, J.P., Insurance Experiment Group, *Free for All? Lessons From the RAND Health Insurance Experiment* (Cambridge, MA: Harvard University Press, 1993).

[15] Baicker, Katherine and Goldman, Dana, "Patient Cost-Sharing and Healthcare Spending Growth," *Journal of Economic Perspectives* 25, no. 2 (2011): 47–68.

[16] Chandra, Amitabh, Flack, Evan, and Obermeyer, Ziad, "The Health Costs of Cost-Sharing," *NBER Working Paper* No. 28439 (2021 February).

[17] Baicker, Katherine, Mullainathan, Sendhil, and Schwartzstein, Joshua, "Behavioral Hazard in Health Insurance," *Quarterly Journal of Economics* 130, no. 4 (2015 November): 1623–1667.

[18] Baicker, Katherine and Levy, Helen, "Cost Sharing as a Tool to Drive Higher-Value Care," *JAMA Internal Medicine* 175, no. 3 (2015 March): 399–400.

[19] Chernew, Michael E., Rosen, Allison B., and Fendrick, A. Mark, "Value-Based Insurance Design," *Health Affairs* 26 (2007): w195–w203.

[20] Baicker, Katherine and Chandra, Amitabh, "What Values and Priorities Mean for Health Reform," *New England Journal of Medicine* 383, (2020 October 8): e89.

[21] Shepard, Mark, Baicker, Katherine, and Skinner, Jonathan, "Does One Medicare Fit All? The Economics of Uniform Health Insurance Benefits," *Tax Policy and the Economy* 34 (2020): 1–41.

Another advantage of plan competition is that it has the potential to drive down costs and accelerate valued innovation.[22] This requires true competition within the insurer market (as well as among clinicians, hospitals, innovators, and other health-care institutions), however, which is not the case in many parts of the country.

The Medicare program provides vital access to care and financial protection for millions of Americans. Ensuring that it provides the best health outcomes possible while maintaining financial sustainability and affordability—both for individual beneficiaries and for the taxpayers of today and tomorrow who must fund the benefits—should be a policy priority. Evidence points to opportunities to reform provider payments and benefit design to focus health-care resources where they will do the most to improve health and well-being.

I thank you again for this opportunity and look forward to answering any questions you may have.

PREPARED STATEMENT OF HON. RICHARD BURR,
A U.S. SENATOR FROM NORTH CAROLINA

Thank you, Chair Warren, for holding this hearing. I think it is past time to have an honest conversation with the American people about the hard decisions that are needed to make Medicare sustainable for future generations.

It is my hope that this hearing will allow us to demonstrate the stark contrast between those who want to end Medicare as we know it, and those of us who want to save it.

The hospital insurance trust fund, which finances Medicare Part A, will be depleted in 2026, at which time Part A payments will be drastically reduced. According to the Medicare trustees, beneficiary access to health-care services could be rapidly curtailed.

No one thinks this should be allowed to happen.

This issue isn't just looming on the horizon—it's here. Benefits will be cut in just 4 short years if we fail to act.

Rather than make false promises about benefit expansions or a so-called "Medicare-for-All" program, we should be honest about what we can afford and figure out how we're going to save Medicare for those who are currently at or near retirement.

I look forward to using my remaining months in the Senate to further this critical conversation, and I hope the rest of my Senate Finance Committee colleagues will join me in efforts to protect this program for generations to come.

PREPARED STATEMENT OF JAMES C. CAPRETTA, SENIOR FELLOW AND
MILTON FRIEDMAN CHAIR, AMERICAN ENTERPRISE INSTITUTE

THE HI TRUST FUND'S SHORTFALL POINTS TO MUCH LARGER FISCAL CHALLENGES

This subcommittee is to be commended for holding this hearing, because the subject matter it will address—the financial outlook for Medicare generally, and status of the program's hospital insurance (HI) trust fund specifically—will require Congress's attention in the near term. Last year, the board of trustees charged with overseeing, and reporting on, the program's financial status projected that HI would be depleted of reserves in 2026.[1] It is not known at this time if this year's report to Congress (due by April 1st according to the Medicare title of the Social Security Act) will alter the projected year of HI depletion.[2]

The decline of HI's reserves is of course, on its own, a problem that should concern Congress because of the importance of ensuring continuity in the provision of

---

[22] Dafny, Leemore and Lee, Thomas, "Health Care Needs Real Competition," *Harvard Business Review* (2016 December).

[1] "2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds," The Boards of Trustees of Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, August 31, 2021, *https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf*. Hereafter, the report is referenced as the 2021 trustees' report.

[2] *See* section 1817(b)(2) of the Social Security Act, *https://www.ssa.gov/OP_Home/ssact/title18/1817.htm*.

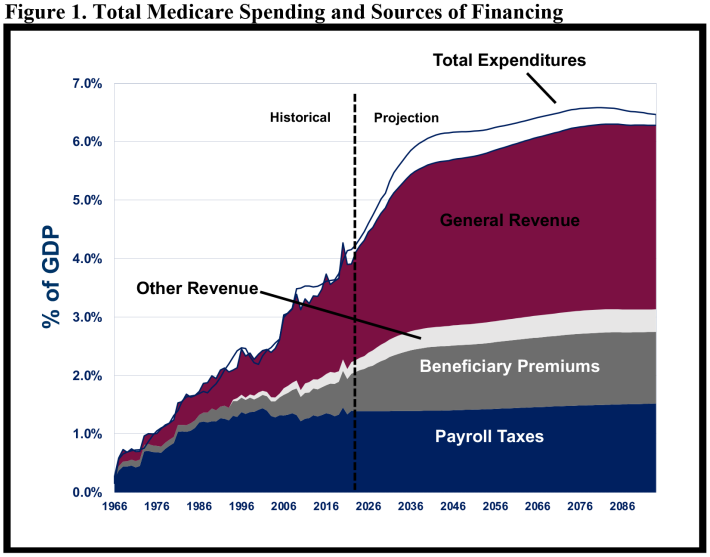
medical services. If HI were to have insufficient funds to pay fully for all of the claims it receives, it is likely that providers would get paid a fraction of what current regulations would allow, which might then jeopardize access to care for some beneficiaries. Congress has never allowed such a scenario to occur, and it is unlikely to do so in this instance either. There is every reason to expect corrective legislation will be passed in time to prevent an interruption of benefit payments.

However, even if near-term depletion of HI is averted, that will not resolve the fundamental problem because HI's issues really are symptoms of a larger fiscal challenge.

The imbalance between HI spending and outgo is a manifestation of the widening gap between Medicare's *total* costs, for both HI *and* Supplementary Medical Insurance (SMI), and the receipts (taxes and premiums) collected to pay for both trust funds' expenses.

Figure 1 replicates the key projection data for all of Medicare's costs and receipts from the 2021 trustees' report, shown as a percentage of Gross Domestic Product (GDP), from the program's inception through the projection period covering the next 75 years. The core problem is the rapid growth of total Medicare spending, driven by an aging population and escalating costs for services, not strictly (or even primarily) an imbalance in HI-only income and outgo.[3]

Figure 1. Total Medicare Spending and Sources of Financing



Source: Medicare Trustees (2021)

In 1990, total program spending equaled 1.9 percent of GDP; 3 decades later, it had reached 4.0 percent of GDP. Medicare's trustees expect costs will exceed 5.0 percent of GDP in 2030 and 6.0 percent in 2050.[4]

What is striking about this figure is what it reveals about the general revenue financing of Medicare. At enactment, SMI was supposed to be financed from beneficiary premiums covering half of its expenses, with the remainder covered by transfers from the general fund of the Treasury. Over time, the share covered by premiums was allowed to fall to 25 percent, which is where it remains. The other 75

[3] These projections may be too optimistic, according to the actuaries who produce estimates of future Medicare spending and receipts, because they assume a perpetual widening between what is paid for services by Medicare relative to commercial insurance, driven by payment limits enacted by Congress in 2010 and 2015. *See* "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," John D. Shatto and M. Kent Clemens, Centers for Medicare and Medicaid Services, August 31, 2021, *https://www.cms.gov/files/document/illustrative-alternative-scenario-2021.pdf.*

[4] The 2021 trustees' report, *https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf.*

percent of expenses paid from SMI—for physician services, prescription drugs, and other ambulatory care—comes from the general fund of Treasury, which is just another way of saying other taxes the Federal Government collects, and funds that the Treasury borrows to cover annual budget deficits.

The transfers from the Treasury are not subject to limitation; they occur automatically and are set at levels that ensure the SMI trust fund is perpetually solvent. Thus, Congress is never asked to "rescue" SMI because the trust fund is never in danger of being depleted.

But that does not mean it imposes no economic burden on taxpayers, because it does. As shown in Figure 1, the transfers to SMI are very substantial, and escalating rapidly. The 2021 trustees' report estimates the transfers to SMI will total $5.3 trillion over the next decade alone. By 2050, the annual transfer will equal 2.8 percent of GDP, up from 0.7 percent in 2000.

Again, these funds must come from taxpayers at some point, either immediately in the form of current taxes, or in the future as tax collections to pay off the debt that was incurred to keep paying benefits in previous years.

The Department of the Treasury releases an annual statement covering the financial status of the entire Federal Government, and uses accrual accounting to present as much of the data as is practical. Accrual accounting attempts to take into account new benefit obligations earned under the rules of various entitlement programs in relation to the expected revenue to pay for them, and uses discounting to present the streams in present value terms. The difference between the cumulative totals for spending and receipts can be presented as the unfunded liability that will need to be closed in some fashion.

For Medicare, the trend line of the estimated unfunded liabilities is what is most alarming. As shown in Table 1, in the most recent report, released in March 2021, Medicare had a combined unfunded liability of $45.7 trillion as of 2020, up from $32.5 trillion in 2016.[5]

Table 1. Medicare's Accrued Unfunded Liabilities

($ trillions)

	2016	2017	2018	2019	2020
Open Group Method	32.5	33.5	37.7	42.2	45.7

Source: Department of the Treasury (2021).

The growing gap between Medicare's total expenditures and the receipts dedicated to paying for them also is central to the adverse fiscal outlook for the Federal budget as a whole, as reflected in data published by the Congressional Budget Office (CBO) and summarized in Table 2.

Table 2. Overview of Key Federal Budget Aggregates (Historical and Projected)

(% of GDP)

	1980	2000	2021	2030	2050
Social Security	4.2	4.0	5.0	5.9	6.3
Medicare (Gross)	1.3	2.2	3.7	5.1	7.7
Other Health	0.4	1.0	2.7	2.5	3.1
Defense	4.8	2.9	3.3	2.8	3.3
Rest of Government	8.6	5.4	14.4	4.1	2.7
Net Interest	1.9	2.2	1.5	2.5	8.2
Total Spending	21.2	17.7	30.6	22.9	31.3

[5] "Financial Report of the United States Government: Fiscal Year 2020," Department of the Treasury, March 25, 2021, *https://fiscal.treasury.gov/files/reports-statements/financial-report/2020/fr-03-25-2021-(final).pdf*. The unfunded liability calculation presented here is based on the open group method, which includes all current and future participants in the Medicare program.

Table 2. Overview of Key Federal Budget Aggregates (Historical and Projected)—Continued

(% of GDP)

	1980	2000	2021	2030	2050
Total Revenues	18.5	20.0	17.2	17.7	18.4
Annual Surplus (+) or Deficit (-)	−2.6	+2.3	−13.4	−5.1	−12.8
Federal Debt	25.5	33.7	102.7	104.5	195.3

Source: CBO (Historical Tables and Long-Term Projections).

The same demographic and health-specific factors pushing up Medicare's expenses are also increasing costs in Social Security and Medicaid. The combined expense of these programs is the principal reason the Federal Government is running large deficits today and will run sustained and widening deficits over the next 3 decades.

As is shown in the table, spending on Medicare, along with Social Security, Medicaid, and other health entitlements, has grown steadily for decades. In 2050, CBO expects the combined spending on these programs will be equal to 17.1 percent of GDP, up from 5.9 percent of GDP in 1980. In 2050, obligations for just these programs will consume nearly all expected Federal revenue.

Rising expenses for the major entitlement programs, without a commensurate increase in revenues, will push Federal borrowing up very rapidly. In 2050, CBO projects the annual budget deficit will reach 12.8 percent of GDP, and cumulative Federal debt will have grown to nearly 200 percent of GDP, up from 25.5 percent in 1980.

Borrowing at such a pace is outside of all historical experience for the United States, and almost certainly would lead to a crisis. One possibility is that the U.S. dollar would gradually lose its position as the world's reserve currency, which would then precipitate a substantial rise in the cost of borrowing funds in public markets. If net interest payments spike, there will be less funding available for other public priorities, which might then force policymakers to enact painful austerity measures.

USING THE SAME TAX FOR TWO PURPOSES UNDERMINES FISCAL DISCIPLINE

The administration has proposed several tax policies to extend the solvency of the HI trust fund, but the implications of these policies are not well understood.

A major problem, as explained by the Committee for a Responsible Federal Budget (CRFB), is that the administration's plan would use Federal tax receipts twice: the taxes would be deposited into the HI trust fund, thus slowing the depletion of its reserves. At the same time, the taxes also are dedicated to offsetting new spending plans outside of Medicare.[6] Put another way, one tax is planned to be used to pay for two streams of Federal expenditures.

One of the administration's proposals for HI solvency is to transfer the receipts from a tax created in the Affordable Care Act (ACA)—the net investment income tax, or NIIT—from the Treasury's general fund to HI. CRFB estimates that this transfer would increase HI receipts by $430 billion over 10 years, and by $2.15 trillion over 30 years. There would be no additional Federal revenue generated by this policy, however. Rather, it would divert the revenue from the existing tax, which was instrumental in 2010 in ensuring the ACA was estimated by CBO as not increasing Federal deficits. In other words, this tax paved the way for ACA's enactment, and now would be used to extend HI solvency.

The administration also proposes to tighten the rules around the implementation of the NIIT, along with the Self-Employment Contributions Act (SECA), which would generate new revenue of $235 billion over 10 years and $1.2 trillion over 30 years. However, as proposed, this revenue also would go paying for the Build Back Better legislation in addition to shoring up HI. Again, using the same source of revenue for two purposes actually increases Federal borrowing relative to what would occur if the new tax were to be devoted solely to delaying the exhaustion date of the HI trust fund.

[6] "How Much Would the President's Budget Extend Medicare Solvency?", Committee for a Responsible Federal Budget, June 10, 2021, *https://www.crfb.org/blogs/how-much-would-presidents-budget-extend-medicare-solvency.*

BROADER REFORMS

While it is important to ensure the HI fund is not depleted of all reserves, and that full benefits are paid on a continuous basis, Congress should view HI's challenges as signals that the broader program needs to be updated and reformed. After all, hospital care does not occur without the patient also getting attention from a physician. Many other services and treatments also are usually provided to the patient both before and after an admission occurs. A narrow focus on hospital costs risks perpetuating a fragmentation within Medicare that is outdated.

The following are six aspects of current Medicare that are in need of reform and could be addressed in a plan to improve the program's overall financial outlook.

1. *A Less Fragmented Benefit.* When Medicare was enacted, in 1965, it was modeled on the prevailing private insurance plans of that time, which often provided separate coverage for hospitalizations and physician services. Medicare did so too, and established separate cost-sharing rules for its two parts (A and B). It also paid for A with payroll taxes and B with premiums and general fund transfers. Medicare also did not cover prescription drugs, nor did it limit what beneficiaries must pay out-of-pocket on an annual basis (a so-called "catastrophic cap").

   In the intervening decades, the basic structure of Medicare did not change, but workarounds were created to address the program's limitations. Seniors bought supplemental plans, and HMOs were introduced to provide a more integrated plan (with less cost-sharing) for the beneficiaries. In 2003, Congress added a new part to the program—D—for prescription drugs.

   It is time to bring Medicare's benefit design into line with the standards of today's insurance plans. There should be one cost-sharing structure, and a limit on out-of-pocket costs. Drugs can be covered separately for the time being, but, in time, part D should be folded into the larger plan too. This redesign would lessen the need for supplement coverage, and can be accomplished on a budget neutral basis.

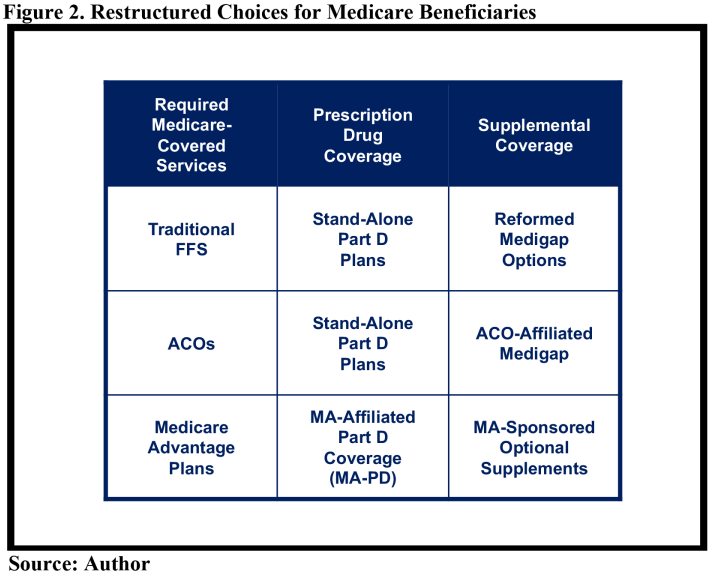
2. *The Choice Structure.* Medicare's origin and evolution have made the program difficult for beneficiaries to navigate. When eligible persons enroll in part A, typically at age 65, they also can voluntarily enroll in parts B (for physician and ambulatory care) and D (prescriptions) by agreeing to monthly premiums covering a portion of their total costs. They also have the option to enroll in Medicare Advantage, or buy a supplemental policy wrapped around the traditional fee-for-service (FFS) benefit.

   Adding to the complexity is the lack of a single coordinated system of enrollment across these components and coverage options. Under current processes, it is not a simple matter for beneficiaries to compare the all-in financial implications of the various combinations of coverage available to them. Many beneficiaries end up relying on brokers to sign up for coverage, even though brokers are often paid by plans seeking to boost enrollment.

   Improving the program and lowering its costs should include simplification of the enrollment process so that beneficiaries can readily identify low-cost, and high-value, options.

   Beneficiaries should be presented with the full range of their benefit options through one, government-administered enrollment portal that makes it less necessary for beneficiaries to rely on outside parties to help them make their choices. Through it, they should be able to compare competing approaches for on an apples-to-apples basis (with standardized benefits) and across the three main benefit components, as shown in Figure 2.

Figure 2. Restructured Choices for Medicare Beneficiaries



Source: Author

Accountable Care Organizations (ACOs)—now a subpart of FFS—should become a coverage option that is distinct from both FFS and MA. ACOs differ from MA plans in that they are organized and run by the hospitals and physician groups providing care to patients, not insurance companies. Some Medicare beneficiaries may be comforted by this distinction. ACOs also are not traditional FFS because they need to have systems in place for coordinating care across settings and disciplines.

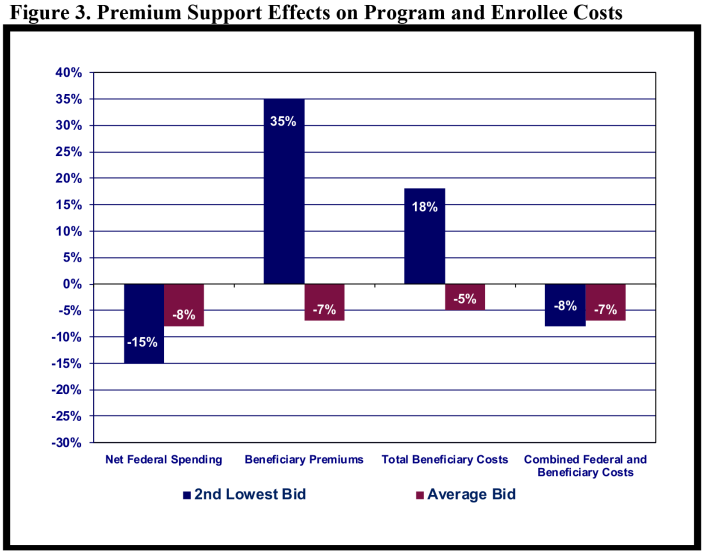
3. *Premium Competition.* CBO has confirmed that strong competition among the coverage options can lower Medicare's costs, and those imposed on the beneficiaries, but reform in the payment system is needed to achieve these results.

   MA plans already submit competitive bids under current law, but those bids are considered in relation to benchmarks tied in part to historical cost rates that may not accurately reflect what spending would be with efficient care provision. Further, FFS does not participate in the bidding process, in that its enrollees pay the same premium irrespective of the relative cost of FFS to other plans. The exemption of FFS from competition has been an impediment to more vigorous premium competition.

   Fair competition requires submission of bids from FFS, ACOs, and MA plans for the same set of standardized benefits, as defined in a reformed Medicare benefit package. FFS's bid would be a calculation by the government based on the per beneficiary costs in each market. The government could refine its risk adjustment methodology to ensure the competition is based on efficient care delivery and not differences in the underlying health status of the enrollees.

   The government's contribution toward coverage (its "premium support") would be based on the submitted bids. CBO has estimated that, if the government set its contribution based on the average bid, there would be savings both for the government and the beneficiaries, as shown in Figure 3. The government's costs would fall by 8 percent, and the beneficiaries would pay 5 percent less in out-of-pocket costs and premiums.

Figure 3. Premium Support Effects on Program and Enrollee Costs



Source: CBO (2017)

CBO's assessment confirms that competition would lower costs by encouraging migration toward more efficient coverage options. It also suggests that the competition likely would slow cost growth in future years by encouraging the development and adoption of cost-reducing technologies that improve the efficiency of care delivery.[7]

4. *Competition and Price Shopping in FFS.* Premium support is not the only means by which stronger market discipline can be introduced into Medicare. Enrollees in FFS can be encouraged to select low-cost and high-quality service providers too, in managed care plans or FFS.

   For this to occur, Medicare will need to become a leader in using standardized pricing to foster strong competition among service providers. Not all medical care is amenable to consumer discretion, but some is (perhaps 40 to 50 percent). Hospitals and physicians today have weak incentives to post clear pricing for their services, and the complexity of medical care makes price comparisons difficult for patients when multiple line items are billed for a full episode of care.

   Medicare could promote strong provider competition by requiring participating facilities and practitioners to disclose their prices for standardized services covering common procedures and services.[8] Further, this requirement should force those providing services to work with each other to provide one, all-in price covering a full episode of care. It is essential that what is being priced be standardized, and cover the full range of services required to properly take care of what the patient needs.

   An essential added step is an incentive for the Medicare enrollees to want to use lower-priced options. Medicare could do this by calculating benchmarks in every market (based on prevailing FFS rates) for the list of standardized interventions. Beneficiaries opting for providers who post prices below the benchmarks should get to keep some of the savings (perhaps 50 percent). In some cases, for expensive care (such as common surgeries), the payment to the Medi-

[7] "A Premium Support System for Medicare: Updated Analysis of Illustrative Options," Congressional Budget Office, October 2017, *https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53077-premiumsupport.pdf.*

[8] For an explanation of the benefits of reference pricing, *see* "Reference Pricing Changes the 'Choice Architecture' of Health Care for Consumers," James C. Robinson, Timothy T. Brown, and Christopher Whaley, *Health Affairs,* March 2017, *https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1256.*

care beneficiary could be substantial, which would create strong incentives for the providers to price their services more aggressively and for the beneficiaries to migrate to the lowest-priced options.

5. *Consolidated Trust Fund.* Medicare's trust funds need updating to mirror the changes recommended for Medicare's insurance design, with parts A and B combined into one insurance plan. With the benefits combined, the trust funds should be merged too (into a singular Medicare trust fund), with all receipts and expenses of the existing HI and SMI trust funds redirected to the combined account.

   A crucial additional reform is the recalibration of the basis for general fund support of the program's spending obligations. It should not be unlimited, as it is today for SMI. Trust funds only work as political signals if their receipts are limited in some way, and are defined to ensure affordability over time. That is distinctly not the case currently, with the government's contribution to SMI expected to rise to levels that will push Federal debt well above what would be sustainable, or advisable.

   One option would be to tie the government's contribution to the new Medicare trust fund to what was paid in a reference year, and then index that amount for subsequent years to the rate of growth in the national economy. This adjustment would ensure that current and future taxpayers contribute the same amount of their combined incomes each year toward ensuring adequate health services for the Nation's elderly and disabled citizens.

   Changing the basis of general fund support for Medicare will not by itself ensure an appropriate political response when trust fund depletion becomes imminent. In a sense, that is the intent—to force elected leaders to grapple with the uncomfortable reality that there is a limit to how much can be borrowed to pay for Medicare benefits. A single trust fund with a limited tap on general revenue would ensure the trust fund was an instrument of fiscal discipline, which is the purpose of such accounting devices.

CONCLUSION

Medicare is one of the Federal Government's most important programs because of the access to medical care it provides to its enrollees. Its financial status should be improved to ensure its benefits are secure for both current and future participants. That will require looking at the financial outlook for all of Medicare and not just HI.

The right reforms have the potential to improve and strengthen Medicare by making the program more efficient rather than cutting benefits. As these changes will take time to implement, Congress should begin to consider and develop the necessary legislation as soon as possible.

Related Papers and Book Chapters:

"Market-Driven Medicare Would Set US Health Care on a Better Course," James C. Capretta, *Economic Perspectives,* American Enterprise Institute, July 2021, *https://www.aei.org/wp-content/uploads/2021/07/Market-Driven-Medicare-Would-Set-US-Health-Care-on-a-Better-Course.pdf.*

"Toward Meaningful Price Transparency in Health Care," James C. Capretta, *Economic Perspectives,* American Enterprise Institute, July 2019, *https://www.aei.org/wp-content/uploads/2019/06/Toward-meaningful-price-transparency-in-health-care.pdf.*

"Structured Markets: Disciplining Medical Care with Regulated Competition," James C. Capretta, American Enterprise Institute, March 2021, *https://www.aei.org/wp-content/uploads/2021/03/Structured-Markets.pdf.*

"Fiscal Rules for Social Security and Medicare: Would Accrual Accounting Help?", James C. Capretta, in *Public Debt Sustainability: International Perspectives,* Barry W. Paulson, John Merrifield, and Steven H. Hanke, eds., Lexington Books, 2022.

PREPARED STATEMENT OF HON. BILL CASSIDY,
A U.S. SENATOR FROM LOUISIANA

First, thank you all for participating in this conversation. This is a diversity of opinion, and I want to thank my chair for agreeing to hold this hearing, but this

is a debate that we should have been having for 6 years now. And the folks who are testifying and the folks who are watching know this. This program goes insolvent in 2026! It's not really years, it's more like months.

We should be addressing Medicare solvency in a more serious fashion than we are. The challenge of the lack of sustainability and the looming insolvency of the Medicare trust fund are being shrugged off as so disastrous that they won't occur. But I'm not sure just ignoring the problem means that it won't occur.

With that said, there are some who would wish to expand the benefit beyond that which we have in a program going insolvent in 2026. That doesn't make sense to me. We have an obligation to the people currently being covered, and yet we would expand and maybe have insolvency come even quicker. By the way, consequences of insolvency under current law would be an immediate cut to providers of roughly 20 to 30 percent, which means just as much money coming in would be paid out.

Dr. Baicker mentioned how providers are sensitive to cost and price. I can promise you, as one of my physician colleagues said, if a doctor is getting paid below cost, you can't make it up on volume. And so, if we're paying someone 20-percent lower than what they're receiving, which would be below their cost, they won't make it up on volume. Which means this becomes an issue of access for those who are Medicare beneficiaries.

There are over 60 million Medicare beneficiaries in the country. Some would suggest that we do away with cost sharing. I'm a doctor, and I can promise you, doctors can prescribe lots of tests, they can prescribe lots of procedures. And there's a lot of data showing that one thing that puts the brakes on it is the one thing that provides just a little bit of cost share. Not too much so that the diabetic does not get her needed care, but a little bit so people think twice.

It comes to mind, I once had a patient call me, and they said, "Doc, you're my liver doctor. My cardiologist ordered a liver test. I have a health savings account and I'll pay for it if I need it, but do I really need it? It's my money and I'd like to know first." I said, "I'm your liver doctor, and you don't need it." So she didn't get it. Contrast that with another patient that I had who was kind of wealthy. She said, "I've got a bells and whistles policy, so I don't care what they charge me because my insurance covers it all."

Now there are consequences to this. My wife's a surgeon, and she once said, "If you do procedures, inevitably you get complications." And when folks are incentivized to over-prescribe whatever it is—drugs, procedures, office visits, et cetera—inevitably there's an associated rate of complication. I think Dr. Baicker referred to this, but I'll use my words not hers. We're trying to find the optimal amount of cost share without overburdening the patient, understanding that measure of burdensomeness changes with the individual patient can change. Let's encourage them to become cost-conscious, to participate in their health care, but not to overwhelm them with the cost, which in turn ends up denying health care.

Traditional fee-for-service is a critical source of care, but in many regards it's outdated. It does nothing to incentivize quality and provider improvement parameters, and there is the "tragedy of the commons" where there is a consumption motivation by both the patient and the physician. And if folks think patients don't demand tests, I can promise you, I have been in the room with patients who've demanded tests which I knew were not necessary. We can quickly make a program that is going insolvent in 2026 go insolvent in 2022, and that is without referring to the motivations that might be among those who might be providing the services.

So this is the state of the program after nearly 60 years of painstaking annual benefit and reimbursement negotiations involving thousands of people here in Washington, bureaucrats if you will, and billions if not trillions of dollars in resources, all the while—to the key point made my Mr. Capretta—subjecting beneficiaries to gaps in benefits, which creates an often hidden cost. Dr. Kapczynski referred to some of this too.

And even with all these resources dedicated to getting incentives aligned, we still have administered pricing, in which the Federal Government pays as little as possible, and then under Medicare Part D, we've allowed companies to offload expense onto the patient. I'm a patient advocate, and that is wrong. We need to fix that as we also attempt to address the other financing challenges.

It's time to take a modern approach to the way we deliver health care. Much of that is going to pertain to how we finance health care. We need an approach that rewards providers for keeping patients out of hospital beds, and one that recognizes

the patient and the doctor, and that relationship, as the ultimate arbiter of value, health, and well-being. We can get there without disrupting the quality and access our constituents need, but the discussion has to begin today.

I thank you all for participating.

PREPARED STATEMENT OF MICHAEL E. CHERNEW, PH.D., CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION

The Medicare Payment Advisory Commission (MedPAC) is a small congressional support agency established by the Balanced Budget Act of 1997 (Pub. L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to pursue Medicare policies that ensure beneficiary access to high-quality care, pay health-care providers and plans fairly by rewarding efficiency and quality, and spend tax dollars responsibly. The Commission would like to thank Chair Warren and Ranking Member Cassidy for the opportunity to testify at this hearing today.

INTRODUCTION

The Medicare program faces a very challenging financial future. In 2021, the Congressional Budget Office (CBO) projected that annual Medicare spending would more than double in the 10-year period between 2021 and 2031, rising from $839 billion to $1.8 trillion (Congressional Budget Office 2021a). During this period, Medicare's share of total Federal spending is expected to rise from 10.1 percent to 18.8 percent (Congressional Budget Office 2021b).[1] CBO also projected that Medicare's hospital insurance (HI) trust fund—which is largely financed by payroll taxes and funds Medicare's payments to hospitals and post-acute care providers, as well as a portion of payments to Medicare Advantage (MA) plans—will become insolvent in 2027. The Medicare trustees project that the HI trust fund will become insolvent a year earlier, in 2026. Without changes to current law or policy, the trustees have estimated that ensuring the solvency of the trust fund for an additional 25 years would require the Medicare payroll tax to be raised from 2.9 percent to 3.7 percent. Alternatively, without revenue increases, Part A spending would need to immediately be reduced by 18 percent (about $70 billion in 2022), an amount that will grow over time if action is delayed (Boards of Trustees 2021).

The continued growth in spending also affects the Supplementary Medical Insurance (SMI) trust fund, which funds payments to physicians and ambulatory care providers, outpatient prescription drug benefits, and a portion of payments to MA plans. The SMI trust fund accounts for a larger share of total Medicare spending than the HI trust fund (60 percent vs. 40 percent). The SMI share is also growing over time; CBO projects that SMI spending will increase to 64 percent of total spending in 2031. The SMI trust fund is financed by a combination of general revenues and beneficiary premiums, so it cannot become insolvent like the HI trust fund. However, the continued growth in SMI spending consumes a growing share of general tax revenues and reduces the funding available for other parts of the budget.

Increasing Medicare spending also strains beneficiaries' household budgets. In 2020, Medicare premiums and cost sharing were estimated to consume 24 percent of the average Social Security benefit, up from 14 percent in 2000. The Medicare trustees estimate that in another 20 years, these costs will consume 31 percent of the average Social Security benefit.

The projected insolvency of the HI trust fund and the need to make spending from the SMI trust fund more sustainable will motivate changes in Medicare spending—at a minimum reducing the rate of spending growth over time. In this spirit, though all policy changes involve tradeoffs, the Commission believes there are policies that will reduce spending without significant deleterious consequences. Spending is only one side of the solvency/sustainability equation; revenues are equally important. However, my comments will be limited to policy changes that would affect Medicare spending. The financing of the Medicare program lies outside the Commission's statutory purview.

---

[1] The 2021 figure is artificially low due to temporary increases in Federal spending related to the coronavirus pandemic. In 2019, the last full year before the pandemic, Medicare accounted for 14.6 percent of Federal spending.

The Commission has identified a number of aspects of Medicare payment systems that hamper the program's ability to achieve fiscal sustainability. We have made—and will continue to make—recommendations that, if implemented, could address these challenges and allow Medicare to improve payment accuracy and equity without sacrificing the quality of or access to care for the program's beneficiaries. For today's hearing, I would like to highlight our work in three areas: annual updates to Medicare's fee-for-service (FFS) payment systems, the MA program, and the prescription drug benefit (Part D).

Annual Updates to FFS Payment Rates

As required by law, the Commission annually makes payment update recommendations for providers paid under Medicare's traditional FFS payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment rate for all providers in a payment system is changed relative to the prior year. In making our update recommendations, we first assess the adequacy of Medicare payments in the current year by considering beneficiaries' access to care, providers' access to capital, and how Medicare payments compare with providers' costs. As part of that process, we examine whether payments will support the efficient delivery of services, consistent with our statutory mandate. We then assess how those providers' costs are likely to change in the year the update will take effect and make a judgment about what, if any, update is needed for the year in question. Next month, we will release our latest March report, which will have recommendations on payment updates for 2023.

I would like to note that our work on payment updates over the past 2 years has focused heavily on the effects of the coronavirus pandemic, which has had catastrophic consequences for many Medicare beneficiaries and affected the entire health-care delivery system. We have been careful to consider the impacts of the pandemic and pandemic-related policies on our measures of payment adequacy in both the short and long term. To the extent that the effects of the pandemic are temporary or vary significantly across providers in a sector, they are best addressed through targeted, temporary funding policies rather than a permanent change to payment rates.

Our assessments of payment adequacy change from year to year based on new data and any underlying changes in a particular payment system, but I would like to highlight that over the last 4 years (spanning our March 2019, March 2020, and March 2021 reports, plus the recommendations that we approved last month and will appear in our March 2022 report), we have consistently found that payment rates for four types of providers—largely in the post-acute care sector, and largely funded through the HI trust fund—are unnecessarily high and could be reduced without compromising beneficiaries' access to care:

- *Skilled nursing facilities* have had Medicare profit margins that exceed 10 percent, continuing a 2-decades-long trend. Over the last 4 years, we have recommended that their annual update for the upcoming year be eliminated (*i.e.,* keeping payment rates the same as in the prior year) and, most recently, that current payment rates also be lowered by 5 percent. CBO estimates that these changes would reduce program spending by more than $10 billion over 5 years.
- *Home health agencies* have had Medicare profit margins that exceed 15 percent, also continuing a long-running trend. Over the last 4 years, we have recommended that their annual update for the upcoming year be eliminated and current payment rates be lowered, most recently by 5 percent. CBO estimates that these changes would reduce spending by between $5 billion and $10 billion over 5 years.
- *Inpatient rehabilitation facilities* have had Medicare profit margins of between 13 percent and 15 percent. Over the last 4 years, we have recommended that the annual update be eliminated and current payment rates be lowered by 5 percent. CBO estimates that these changes would reduce spending by between $5 billion and $10 billion over 5 years.
- *Hospices* have had Medicare profit margins that exceed 10 percent. Over the last 4 years, we have recommended eliminating their annual update and, for the last 3 years, also reducing the annual cap on payments to individual hospices by 20 percent. (The reduction in the cap would apply additional financial pressure to hospices that have very long lengths of stay and relatively high profits.) CBO estimates that these changes would reduce spending by between $5 billion and $10 billion over 5 years.

These recommendations would affect providers of Part A-covered services, so any reductions in their payment rates would lower Part A spending and improve the solvency of the HI trust fund. (Home health is a partial exception because some of its services are covered by Part B.) In addition to their direct effects on providers and FFS spending, these recommendations would have the added benefit of applying a modicum of appropriate financial pressure on MA plans by reducing the spending benchmarks that help determine plan payment rates.

MEDICARE ADVANTAGE

The MA program allows beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional FFS Medicare program. (Since MA plans provide both Part A and Part B services, roughly 40 percent of their funding comes from the HI trust fund and 60 percent comes from the SMI trust fund. They receive separate payments from the SMI trust fund for providing drug benefits.) The Commission strongly supports the inclusion of private plans in the Medicare program because they have the potential to offer more affordable care for beneficiaries while spending less than FFS. Thus, the Commission contends that under the right payment mechanisms, MA plans could serve as vehicles to manage overall spending and quality of care more effectively than the fragmented FFS system. Although MA plans have the potential to provide good value for the program, the methodology that Medicare uses to pay MA plans has several features that prevent that value from materializing and that contribute to the program's solvency and sustainability problems.

The MA program is now quite robust. Enrollment has grown by about 10 percent annually in recent years, and last year 46 percent of eligible Medicare beneficiaries (about 27 million people) were enrolled in plans. If this trend continues, the majority of eligible Medicare beneficiaries will be enrolled in MA in the next few years. Almost all beneficiaries (99 percent) have access to at least one plan, and the average beneficiary has more than 30 plans available in their county. The payments that plans use to provide extra benefits, known as rebates, have also grown rapidly, and this year average nearly $2,000 annually per enrollee, an all-time high.

However, the expansion of MA is also a cause for concern. Private plans that accept full risk have been available in Medicare since the mid-1980s, but our review suggests that they have never yielded aggregate savings for the program. That remains true today. We estimate that in 2022 Medicare payments to MA plans equal about 104 percent of what Medicare would have spent on those same beneficiaries in traditional FFS.

The gap between MA payments and FFS spending primarily reflects three factors. First, policymakers set MA payments above FFS spending levels in low-FFS-spending counties to ensure access to MA plans and the extra benefits offered to MA enrollees in those counties. Specifically, the benchmark for each county equals a percentage of the projected average per capita FFS spending for the county's beneficiaries. Counties are ranked based on their per capita FFS spending and then divided into four quartiles. Benchmarks are set at 115 percent of county FFS spending for the quartile of counties with the lowest FFS spending, 107.5 percent and 100 percent for counties in the next 2 quartiles of FFS spending, and 95 percent for counties in the quartile with the highest FFS spending. In addition to increasing Medicare payments, this quartile system creates cliffs between counties that result in inequitable benchmarks, where counties with similar FFS spending levels can have very different MA payment rates. Second, MA plans are paid more if they serve sicker beneficiaries, but aggressive coding by MA plans and a lack of incentives for providers to similarly code under traditional FFS has led to a poorly calibrated risk adjustment system that leads to higher Medicare spending. Third, MA plans are rewarded for achieving a higher star rating through the quality bonus system, but the Commission has found that the MA quality bonus program boosts plan payments for most MA enrollees, does not meaningfully reflect plan quality in local areas, and should be reformed to better achieve its goals while reducing Medicare spending.

Overall, beneficiaries clearly find MA an attractive option through which to receive their Medicare benefits, as evidenced by the program's strong enrollment growth. However, since Medicare spends more to cover beneficiaries in MA than it does in FFS, the shift toward MA worsens Medicare's sustainability and makes the need for structural improvements to MA more urgent. To encourage efficiency and innovation, MA plans need to face appropriate financial pressure similar to what

the Commission recommends for health-care providers in the traditional FFS program.

To that end, over the past few years the Commission has made three recommendations that would eliminate or reduce what we consider to be the most significant policy flaws in the current program:

Account for coding differences between MA and FFS. Medicare's payments to MA plans are risk-adjusted to account for differences in enrollees' health status, so that plans are paid less for their healthier enrollees and more for their sicker enrollees. The adjustment for each enrollee is partly based on the diagnoses that providers code, which gives MA plans an incentive to record more diagnoses that is largely absent in FFS. To some extent, these structural differences mean that diagnostic coding may be more complete in MA than in FFS (and in some MA plans relative to others). The payment incentive to code more intensely creates risk adjustments that are not comparable between MA and FFS. Furthermore, some plan sponsors put a disproportionate effort into documenting more diagnoses, giving them an unwarranted competitive advantage over other plans in their market. Without rendering a judgment on the accuracy of MA coding (though some plans likely push the bounds of accuracy and the Commission strongly supports efforts to promote program integrity), the key issue is that coding in FFS and MA is not comparable. By law, CMS lowers payments to MA plans in recognition of these coding differences, but these reductions have never accounted for the full extent of the coding differences between MA and FFS.

As a result, the more intense coding in MA relative to FFS leads to higher payments to plans and raises program spending. This year, we found that coding differences mean that payments to MA plans are about 3.6 percent higher than they would have been if MA enrollees were treated in FFS Medicare. In 2020, coding differences boosted payments to plans by about $12 billion. This coding intensity undermines the incentives for plans to improve quality or reduce costs, and the variation in coding intensity across plans generates inequity by giving an advantage to plans that code more extensively.

In 2016, the Commission recommended a three-pronged approach to fully account for the impact of coding differences: (1) develop a risk-adjustment model that uses 2 years of diagnostic data instead of just one year (this would make the FFS diagnostic data more complete and reduce the marginal benefit for MA plans of coding additional diagnoses), (2) exclude any diagnoses that are documented only on a health risk assessment, and (3) apply a coding adjustment that eliminates any remaining differences in coding between FFS Medicare and MA plans (Medicare Payment Advisory Commission 2016). At the time, CBO estimated that these recommendations would reduce Medicare spending by between $1 billion and $5 billion over 5 years.

Replace the quality bonus program. The MA quality bonus program (QBP) provides higher payments to plans that have a rating of 4 stars or better on a 5-star scale. Over the years, the Commission has identified several flaws in the QBP. First, the QBP uses too many quality measures, and many of them are process measures rather than measures that focus on outcomes and patient/enrollee experience. Second, the star ratings are determined at the MA contract level, which may cover very large geographic areas and thus may not be a reliable indicator of the quality of care provided in an individual's local area and may not sufficiently capture variation in quality among subgroups of beneficiaries. This problem has been exacerbated by plan sponsors consolidating contracts to artificially improve their star ratings, an issue that has been partially addressed by legislation. Third, the QBP is financed with additional dollars above and beyond the cost of providing the Medicare benefit, in contrast to FFS quality payment. Lastly, an evaluation of quality in MA would ideally be based in part on a comparison with the quality of care in FFS, but the data needed to compare MA with FFS is lacking.

The Commission has concluded that the current state of quality reporting no longer provides an accurate description of the quality of care in MA, either over time, among MA plans, or relative to FFS Medicare. With almost half of eligible beneficiaries now enrolled in MA plans, it is imperative that beneficiaries be able to compare MA and FFS quality, including alternative payment models in FFS such as Accountable Care Organizations (ACOs), and to compare the performance of the plans available in their area. Policymakers also need better information on the quality of care to monitor MA and FFS performance, evaluate MA payment policy, and assess other elements of the MA program such as network adequacy.

In 2020, the Commission recommended replacing the QBP with a value incentive program that would:

- Use a small set of population-based outcome and patient/enrollee experience measures that, where practical, aligns across MA plans and ACOs. To avoid undue burden on providers, measures should be calculated or administered largely by CMS, preferably with data that are already being reported, such as claims or encounter data.
- Evaluate quality at the local market level to provide beneficiaries with information about the quality of care in their local area and provide MA plans with incentives to improve the quality of care provided in every geographic area.
- Account for differences in enrollees' social risk factors so plans with higher shares of enrollees with social risk factors are not disadvantaged in their ability to receive quality-based payments.
- Finance the MA quality system in a budget-neutral manner to be more consistent with Medicare's FFS quality payment programs, which are either budget neutral (financed by reducing payments per unit of service) or produce program savings because they involve penalties (Medicare Payment Advisory Commission 2020).

Quality bonuses account for about 3 percent of overall Medicare payments to MA plans in 2022, so replacing the QBP with a budget-neutral program would generate substantial program savings. In 2020, CBO estimated at the time that these recommendations would reduce Medicare spending by more than $10 billion over 5 years.

Establish benchmarks that allow the Medicare program to share in the efficiencies generated by Medicare Advantage. In contrast to the traditional FFS program, where Medicare pays providers fixed rates per service, Medicare pays MA plans a fixed rate for each enrolled beneficiary. Plan payment rates are determined by plan bids and benchmarks that are based on local FFS spending. Plans that bid below the benchmark (which nearly all do) receive some of the difference as a rebate that plans must use to provide extra benefits in the form of lower cost sharing, lower premiums, or supplemental benefits. Those benchmarks are increased (usually by 5 percentage points) for plans that receive the quality bonus.

This year, MA plans are able to provide the Part A and Part B benefit package at a lower cost than the FFS program; the average bid equals 85 percent of FFS costs. Medicare customarily has mechanisms that allow it to benefit from the savings that providers or plans generate when they become more efficient. For example, the ACOs that operate in FFS have shared-savings arrangements with Medicare. In MA, Medicare benefits from plans operating more efficiently by keeping some of the difference between plan bids and benchmarks. However, the savings generated by this mechanism are more than offset by the combined effect of high benchmarks and quality bonuses. As a result, the Commission contends that the benchmark system should be revised to allow the Medicare program, its beneficiaries, and taxpayers to share in the savings that MA plans are able to achieve.

Specifically, last year the Commission recommended that the Congress enact a new policy that calculates benchmarks using a relatively equal blend of local area FFS spending and national FFS spending, makes rebates a fixed percentage of the difference between the benchmark and a plan's bid (this percentage would be at least 75 percent; under the current system, the percentage varies based on a plan's star rating), and incorporates a discount rate that reduces all benchmarks by at least 2 percent. This approach would allow the Medicare program to capture some MA efficiencies, while not being overly disruptive to MA plans' ability to earn rebates and offer supplemental benefits to their enrollees (Medicare Payment Advisory Commission 2021). At the time, CBO estimated that this recommendation would reduce program spending by more than $10 billion over 5 years.

The Prescription Drug Benefit (Part D)

Under Part D, Medicare subsidizes about three-quarters of the cost of a basic outpatient drug benefit and provides a low-income subsidy (LIS) that covers much of the cost sharing and premiums for low-income beneficiaries. About 75 percent of Medicare beneficiaries are currently enrolled in Part D. Unlike Part A and Part B, all Part D benefits are delivered through private plans—stand-alone prescription drug plans (PDPs) and Medicare Advantage—Prescription Drug (MA–PD) plans that provide combined medical and drug coverage. Consistent with the growth in MA en-

rollment, the share of Part D beneficiaries enrolled in MA–PDs has risen steadily over time.

Part D has a complicated, three-part benefit design. In the first part of the benefit, beneficiaries may face a deductible and pay cost sharing that equals 25 percent, on average. Part D plans receive capitated payments that largely finance coverage in this stage of the benefit. Beneficiaries with drug costs that exceed the initial part of the benefit then enter a second part known as the coverage gap, where they still face cost sharing of 25 percent but coverage is largely financed by manufacturer discounts on brand-name drugs or the LIS. The third part is a catastrophic benefit for beneficiaries with very high drug spending. In this stage, beneficiaries pay cost sharing of 5 percent (those who receive the LIS pay nothing) and coverage is largely financed by Medicare through cost-based reinsurance.

When Part D started in 2006, most spending was attributable to brand prescriptions for widely prevalent conditions such as high cholesterol and depression. Blockbuster drugs for such conditions lost patent protection toward the end of that decade, and many Part D enrollees switched to generic versions of their medicines. As this occurred, manufacturers turned to developing orphan drugs, biologics, and other high-priced specialty drugs for smaller patient populations. These broader changes to the prescription drug market, combined with Part D's unusual structure, have led us to raise several concerns about the program:

- Part D plans bear little liability for spending after the initial stage of the benefit. In the coverage gap, plans are responsible for just 5 percent of brand spending for enrollees without the LIS and bear no liability for LIS enrollees. In the catastrophic stage, plans cover only 15 percent of spending. When post-sale rebates and discounts that plans collect on some brand-name drugs are taken into account, plan sponsors may actually reduce their costs by covering a more expensive medication over a generic.
- The manufacturer discounts on brand-name drugs in the coverage gap have lowered out-of-pocket costs for some beneficiaries, but they also artificially lower the prices for brand-name drugs relative to generics, which reduces incentives to use generics.
- The shift toward high-cost drugs has effectively turned Part D from a program that relies on capitated, risk-bearing plans to one that largely relies on cost-based payment. In 2007, Medicare's capitated payments to Part D plans were more than twice as large as its cost-based reinsurance payments ($17.6 billion vs. $8.0 billion). By 2020, reinsurance payments were nearly five times larger ($47.8 billion vs. $10.2 billion).
- The growth in spending on high-cost drugs has also increased the number of beneficiaries who reach the catastrophic stage of the benefit. Beneficiaries who reach this stage and do not receive the LIS may still incur substantial out-of-pocket costs.

In 2020, the Commission addressed these concerns by recommending major changes to the Part D program (Medicare Payment Advisory Commission 2020). These changes would substantially redesign the program's benefit structure, restore the role of risk-based, capitated payments that was present at the start of the program, and provide some resistance on drug price increases. This redesign would:

- Eliminate the coverage gap and the discounts that manufacturers provide on brand-name drugs during that part of the benefit. These changes would create a benefit where plans would be responsible for 75 percent of spending for benefits between the deductible and the catastrophic threshold, with enrollees responsible for the remaining 25 percent through cost sharing. (The Medicare program would continue to pay most of the cost sharing for enrollees who receive the LIS.)
- Provide enrollees with greater financial protection by eliminating cost sharing in the catastrophic part of the benefit, thus creating an annual cap on out-of-pocket costs.
- Reduce Medicare's reinsurance in the catastrophic part from 80 percent to 20 percent and require manufacturers to provide a discount of at least 30 percent on high-priced medicines. Plans would be responsible for the remaining 50 percent. These changes would shift insurance risk from Medicare to plan sponsors and drug manufacturers.

- Improve the ability of plans to manage drug spending more effectively by establishing a higher copayment amount under the LIS for nonpreferred drugs and by giving plans greater flexibility in covering drugs in the protected classes.

In tandem with these changes, CMS would need to recalibrate its risk-adjustment system for Part D payments to ensure that they adequately account for differences in enrollees' health status. Since plans would bear more insurance risk in the catastrophic stage of the benefit under these reforms, policymakers could also consider modifying the Part D risk corridors to temporarily provide plans with greater protection during a transition to the new benefit structure.

In 2020, CBO estimated that this package of recommendations would reduce program spending by more than $10 billion over 5 years.

CONCLUSION

Medicare spending is expected to more than double over the next decade due to a combination of higher enrollment driven by the retirement of the baby boomers and continued growth in per capita spending in all parts of the program. This spending growth will strain the solvency of the HI trust fund and the sustainability of the general revenue—financed SMI trust fund. By design, consistent with the Commission's statutory charge, I have discussed only the spending side of Medicare's sustainability problem. The recommendations I have discussed today touch on some key areas where the Commission contends that reforms are both urgently needed and could be implemented in a way that reduces program spending, continues to pay providers and health plans adequately for delivering services, and ensures that beneficiaries have good access to care.

References

Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2021. *2021 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* Washington, DC: Boards of Trustees.

Congressional Budget Office. 2021a. *Baseline projections—Medicare.* Washington, DC: CBO. *https://www.cbo.gov/system/files/2021-07/51302-2021-07-medicare.pdf.*

Congressional Budget Office. 2021b. *An update to the budget and economic outlook: 2021 to 2031.* Washington, DC: CBO. *https://www.cbo.gov/system/files/2021-07/57218-Outlook.pdf.*

Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare and the health-care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health-care delivery system.* Washington, DC: MedPAC.

PREPARED STATEMENT OF AMY KAPCZYNSKI, PROFESSOR AND FACULTY CO-DIRECTOR, GLOBAL HEALTH JUSTICE PARTNERSHIP AND LAW AND POLITICAL ECONOMY PROJECT, YALE LAW SCHOOL

Chair Warren, Ranking Member Cassidy, and distinguished members of the subcommittee, I appreciate the opportunity to testify about the important topic of the future of Medicare financing.

My name is Amy Kapczynski, and I am a professor of law at Yale Law School, as well as a faculty co-director of the Yale Global Health Justice Partnership and the Law and Political Economy Project. I teach and write about intellectual property law, innovation policy, and law and political economy. My research has had a particular focus on the pharmaceutical industry and organization of biomedical research and development in the U.S.

The focus of my remarks today will be on the problem that high drug prices pose for the Medicare program and for Medicare beneficiaries. At the root of this problem is the monopoly power that companies can exert through patents and other market exclusivities. As I will describe, the vast majority of Medicare's rising drug expenditures are attributable to high-cost, monopolized medicines. Ensuring the stable fi-

nancing of Medicare, and the health and well-being of Medicare beneficiaries, requires concerted legislative action to ensure fair pharmaceutical prices.

There is a great deal of talk in Washington today about inflation. I urge you to consider why drug price inflation—which we know how to handle, and which hurts so many vulnerable Americans—has been allowed to persist without congressional action. To protect Medicare, and to protect Americans, Congress should pass strong legislation to curb price increases and ensure that medicine prices reflect genuine investment and therapeutic value, and also consider measures to address patent-abuse and other anticompetitive conduct in the industry.

HIGH DRUG PRICES ARE A CRITICAL PROBLEM FOR AMERICANS AND FOR MEDICARE

High drug prices in the U.S. are a major problem today, both for patients and for the sustainability of our health insurance system. From 1980 to 2018, pharmaceutical spending increased more than tenfold in real terms (*i.e.,* excluding economy-wide inflation).[1] U.S. spending on prescription drugs reached $535.3 billion in 2020.[2] Pharmaceutical spending accounts for at least 14 percent of overall U.S. health-care spending.[3]

Price increases beyond the pace of inflation are commonplace, for example with net prices increasing by 60 percent from 2007 to 2018.[4] More than 100 drugs saw price increases beyond inflation in 2021.[5] The average new cancer drug in the U.S. today is priced at more than $175,000, and this price does not in any logical way track benefits or R&D costs.[6] The U.S. is also distinctive among other wealthy countries. We lack comprehensive tools to ensure fair prices, and as a result have prices that are on average 256 percent higher than all other OCED countries.[7]

Unsurprisingly, high drug prices are also one of the leading concerns of voters today.[8] More than two-thirds of Americans across political affiliations say, for example, that lowering high drug prices should be a high priority for the current administration.[9] Almost two in five (39 percent) of Americans did not take a prescription

---

[1] Congressional Budget Office, *Prescription Drugs: Spending, Use, and Prices 1* (2022).

[2] Eric M. Tichy, "National Trends in Prescription Drug Expenditures and Projections for 2021," 78 *Am. J. Health-System Pharmacy* 1294, 1295 (2021), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8365501/pdf/zxab160.pdf.* CMS also produces an estimate of U.S. pharmaceutical spending. *See* Centers for Medicare and Medicaid Services, *National Health Expenditures 2020 Highlights 2* (2021) (estimating U.S. pharmaceutical spending at $348.4 billion). However, the CMS estimate only captures drug spending in retail outlets. Although estimates of retail—*i.e.,* pharmacy-dispensed—drugs come in around 9 percent of total health-care spending, including *non-retail* drugs increases estimates by as much as 50 percent. CMS counts this form of spending as "physician, hospital, and nursing home services," making traditional estimates of stand-alone drug spending problematic. *See* Rena M. Conti et al., "Projections of U.S. Prescription Drug Spending and Key Policy Implications," *JAMA Health Forum* (2021), *https://jamanetwork.com/journals/jama-health-forum/fullarticle/2776040.*

[3] Tichy, *supra* note 2, at 1294; *see also* Charles Roehrig, *Projections of the Prescription Drug Share of National Health Expenditures Including Non-Retail,* Altarum Research Brief (June 13, 2019), *https://altarum.org/publications/projections-prescription-drug-share-national-health-expenditures-including-non-retail-0* (finding total prescription drug spending to be 13.9 percent not the more oft-quoted 9 percent figure); Aaron S. Kesselheim, *Improving Competition to Lower U.S. Prescription Drug Costs,* Washington Center for Equitable Growth (February 18, 2020) (suggesting that the share is closer to 20 percent, or even 25 percent for some private insurers).

[4] Inmaculada Hernandez et al., "Changes in List Prices, Net Prices, and Discounts for Branded Drugs in the U.S.," 2007–2018, 323 *JAMA* 854 (2020), *https://jamanetwork.com/journals/jama/fullarticle/2762310.*

[5] Patients for Affordable Drugs, *A New Year Brings the Same Old Bad Behavior by Big Pharma* (2022), *https://patientsforaffordabledrugs.org/2022/01/12/a-new-year-brings-the-same-old-bad-behavior-by-big-pharma; see also* Dena Bunis, *Prescription Drug Price Increases Continue to Outpace Inflation,* AARP (June 7, 2021), *https://www.aarp.org/politics-society/advocacy/info-2021/prescription-price-increase-report.html* (describing how "prices for 260 commonly used medications whose prices AARP has been tracking since 2006 increased 2.9 percent while the general rate of inflation was 1.3 percent").

[6] Vinay Prasad, Kevin De Jesús and Sham Mailankody, "The High Price of Anticancer Drugs: Origins, Implications, Barriers, Solutions," 14 *National Reviews Clinical Oncology* 381 (2017), *https://doi.org/10.1038/nrclinonc.2017.31.*

[7] Andrew W. Mulcahy et al., Rand Corporation, *International Prescription Drug Price Comparisons: Current Empirical Estimates and Comparisons With Previous Studies* (2021), *https://www.rand.org/pubs/research_reports/RR2956.html.*

[8] Liz Hamel, *Public Opinion on Prescription Drugs and Their Prices,* Kaiser Family Foundation (2021), *https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/.*

[9] Dan Witter, *In U.S., Most Say Reducing Cost of Care High Priority for Biden,* Gallup (January 28, 2021), *https://news.gallup.com/poll/328757/say-reducing-cost-care-high-priority-biden.aspx.*

drug as prescribed because of cost.[10] One in five (21 percent) reported taking on debt or declaring bankruptcy in order to pay for their prescriptions.[11] The same percent also reported struggling to pay for basic needs such as food or shelter as a result of their prescription drug spending.[12]

The effects of the costs of treatment are so dramatic and clear to clinicians that some oncologists have even coined the term "financial toxicity" to describe the consequences of high treatment prices on cancer patients.[13] Indeed, recent estimates indicate that medical debt has become the single leading source of delinquent consumer debt in the U.S., surpassing credit cards, utilities, and phone bills over the last decade.[14]

Another vivid example of the problem is insulin, a drug that type 1 diabetics must take regularly or face life-threatening consequences. In the past 2 decades, the cost of analogue insulins has skyrocketed, even as the drugs themselves remain unchanged. For example, Novolog, an insulin that has been on the market since 2001, saw its price rise by 353 percent between 2001 and 2016.[15] The human costs are severe. Researchers have found that as many as 1 in 4 patients now do not take insulin as prescribed due to its unaffordability.[16]

HIGH DRUG PRICES HAVE A SIGNIFICANT IMPACT ON MEDICARE

The impact of high drug prices on Medicare specifically is well-documented. Medicare covers retail prescription drugs through Part D, drugs provided in physicians' offices and hospital outpatient departments through Part B, and inpatient and nursing facilities through Part A. These programs cover an estimated 27 percent of all U.S. drug spending.[17]

These expenditures make up a significant part of Medicare budgets. Between 2006 and 2017, drug spending through Medicare Part D rose from 9 percent of total benefit payments to 14 percent.[18] This in part reflects increases in drug prices that

---

[10] Katie Adams, "Rising Costs Force 39% of Americans to Skip, Ration Meds, Survey Says," *Becker's Hospital Review* (March 22, 2021), *https://www.beckershospitalreview.com/pharmacy/rising-costs-force-39-of-americans-to-skip-ration-meds-survey-says.html* (citing a survey of roughly 1,000 Americans conducted by GoodRx).

[11] *Id.*

[12] *Id.*

[13] Cathy J. Bradley, K. Robin Yabroff and Ya-Chen Tina Shih, "A Coordinated Policy Approach to Address Medical Financial Toxicity," 7 *JAMA Viewpoint* 1761 (2021), *https://jamanetwork.com/journals/jamaoncology/fullarticle/2784986; see also* Scott D. Ramsey, et al., "Financial Insolvency as a Risk Factor for Early Mortality Among Patients With Cancer," 34 *Journal of Clinical Oncology* 980 (2016) (finding an association between medical debt and early mortality among cancer patients).

[14] Raymond Kluender, Neale Mahoney and Francis Wong, "Medical Debt in the U.S., 2009–2020," 326 *JAMA* 250 (2021), *https://jamanetwork.com/journals/jama/fullarticle/2782187.* Kluender and coauthors estimated that the amount of medical debt currently in collections—a tiny fraction of the total medical debt burden—to be $140 billion. In contrast, an earlier study estimated medical debt in collections in 2016 to be $81 billion. *See* Michael Batty, Christa Gibbs and Benedic Ippolito, "Unlike Medical Spending, Medical Bills In Collections Decrease With Patients' Age," 37 *Health Affairs* 1257 (2018), *https://doi.org/10.1377/hlthaff.2018.0349.*

[15] The Endocrine Society, "Addressing Insulin Access and Affordability: An Endocrine Society Position Statement," 106 *J. Clinical Endocrinology and Metabolism* 935, 936 (2021).

[16] Darby Herkert et al., "Cost-Related Insulin Underuse Among Patients With Diabetes," 179 *JAMA Internal Medicine* 112 (2019).

[17] Office of Health Policy, Office of Assistant Secretary for Planning and Evaluation, *Medicare Part B Drugs: Trends in Spending and Utilization,* 2016–2017 (2020), *https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//197396/Part-B-Drugs-Trends-Issue-Brief.pdf.*

[18] Juliette Cubanski and Tricia Neuman, Kaiser Family Foundation, *The Facts on Medicare Spending and Financing* (July 2017), *https://collections.nlm.nih.gov/master/borndig/101717009/Issue-Brief-The-Facts-on-Medicare-Spending-and-Financing.pdf; see also* Xavier Becerra, *Report to the White House Competition Council* (2021), *https://aspe.hhs.gov/sites/default/files/2021-09/Competition%20EO%2045-Day%20Drug%20Pricing%20Report%209-8-2021.pdf* ("Medicare spending on drugs is growing faster than Medicare spending on other services: 5.9 percent annually on Part B Fee-for-Service drugs and Part D, compared to 5.3 percent for the program as a whole. Drug spending per beneficiary on Medicare Part B, which covers drugs administered in physician offices and hospital outpatient departments, has increased roughly 8 percent each year since 2006, and nearly 10 percent from 2017–2018, compared to about 6 percent annually for overall Part B spending. Medicare Part B drug spending has been growing even more sharply in recent years. With no cap on out-of-pocket spending in Medicare Part D, beneficiaries who need expensive drugs or many different drugs to treat chronic conditions can be hit particularly hard: in 2019, nearly 1.5 million beneficiaries had out-of-pocket spending above the catastrophic threshold that is currently set at $6,550, with 3.6 million beneficiaries having had out-of-pocket

Continued

significantly outpaced inflation.[19] Indeed, among Medicare Part D drugs, the median price increases were 3.5 times the rate of inflation.[20]

High drug prices thus are a major challenge for Medicare financing. One study estimated that reducing the prices paid by Medicare for only brand-name drugs to those paid by other government providers such as the Veterans Health Administration would decrease taxpayer contributions by at least $11 billion each year.[21] Similarly, the CBO has estimated that various legislative proposals that would allow the government to negotiate drug prices through Medicare would save the program anywhere from $80 to nearly $500 billion over 10 years.[22]

High drug prices are not just a problem for the fiscal sustainability of the program. They are also a major problem for Medicare beneficiaries because they translate into greater cost-sharing burdens. Medicare patients are on the hook for a percentage of their treatment costs due to coinsurance obligations, which apply even after they have met their deductibles and out-of-pocket maximums. These sums can be exorbitant when drugs cost as much as $75,000 per year.[23] On top of this, Medicare deductibles have risen faster than inflation, including for the Part D drug program.[24] And increases in premiums can also be driven by the introduction of expensive new medicines, as this year's 14.5 percent increase in Part B premiums shows.[25]

For seniors on Medicare who have common, chronic conditions (like diabetes and high blood pressure), out-of-pocket costs rose by over 40 percent between 2009 and 2019.[26] Note that this figure understates the true cost of the price increase because the overall costs of medication are shared by all Medicare beneficiaries through their premiums. Even so, this increase far outstripped the overall inflation rate over that period.[27] This increase was driven not by exogenous factors like supply shortages or labor costs, but by the development of new, patent-protected drugs without generic competitors. The same researchers found that costs for patients whose conditions were treated with generic drugs saw out-of-pocket costs fall during the same period, while those who were treated with brand drugs lacking generic competitors saw the largest increases.[28]

---

spending above the catastrophic threshold in at least 1 year over the 10 year period from 2010–2019.").

[19] Drug prices outpaced inflation in half of all Part D-covered drugs (1,646 drugs) between July 2018 and July 2019. Juliette Cubanski and Tricia Neuman, Kaiser Family Foundation, *Price Increases Continue To Outpace Inflation for Many Medicare Part D Drugs* (2021), *https://www.kff.org/medicare/issue-brief/price-increases-continue-to-outpace-inflation-for-many-medicare-part-d-drugs/*. The inflation rate in this article is based on CPI–U.

[20] *Id.*

[21] Marc-Andre Gagnon and Sidney Wolfe, Public Citizen, *Mirror, Mirror on the Wall: Medicare Part D Pays Needlessly High Brand-Name Drug Prices Compared With Other OECD Countries and With U.S. Government Programs* (2015), *https://www.citizen.org/wp-content/uploads/2269a.pdf.*

[22] *See* Congressional Budget Office, Division A—Prescription Drug Pricing Reduction Act of 2019 (2020), *https://www.cbo.gov/system/files/2020-03/PDPRA-SFC.pdf;* Report from Phillip L. Swagel, Director, Congressional Budget Office, to Frank Pallone Jr., Chairman, House Committee on Energy and Commerce (December 10, 2019), *https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf* (Budgetary Effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act); *see also* Lovisa Gustafsson and Rachel Nuzum, *The Case for Drug-Pricing Reform—The Cost of Inaction,* Commonwealth Fund (May 26, 2021), *https://www.commonwealthfund.org/blog/2021/case-drug-pricing-reform-cost-inaction* (describing generally various possible reforms and their potential for significant cost-savings).

[23] Michelle Andrews, "Doughnut Hole is Gone, But Medicare's Uncapped Drug Costs Still Bite Into Budgets," *Kaiser Health News* (March 29, 2019), *https://khn.org/news/doughnut-hole-is-gone-but-medicares-uncapped-drug-costs-still-bite-into-budgets/*.

[24] Mark Miller, "How to Cope With Medicare's Rising Costs," *New York Times* (December 22, 2021), *https://www.nytimes.com/2021/12/22/business/medicare-retirement-costs.html?smid=url-share.*

[25] Dena Bunis, "AARP Urges Feds to Lower 2022 Part B Premiums," *AARP Health* (January 25, 2022), *https://www.aarp.org/health/medicare-insurance/info-2022/part-b-premium-increase-reassess-alzheimers-drug.html.*

[26] Reshma Ramachandran, Tianna Zhou and Joseph S. Ross, "Out-of-Pocket Drug Costs for Medicare Beneficiaries Need to Be Reined in," *STAT News* (January 7, 2022), *https://www.statnews.com/2022/01/07/out-of-pocket-drug-costs-for-medicare-beneficiaries-need-to-be-reined-in.*

[27] The overall inflation rate in the period was roughly 19 percent, according to U.S. Bureau Labor Statistics, CPI Inflation Calculator (last visited January 31, 2022), *https://www.bls.gov/data/inflation_calculator.htm* (calculating the rise in CPI–U from January 2009 to January 2019).

[28] Ramachandra, *supra* note 25.

A 2021 study published in the *Journal of the American Medical Association* found that 11 percent of Medicare beneficiaries reported delaying care due to concerns about cost, 11 percent reported difficulty paying medical bills, and 16 percent reported at least one of these problems.[29] The burden, predictably, fell hardest on the poor and those with multiple chronic conditions.[30] Since then, the problem has continued to worsen, with the most recent evidence showing dramatic increases in the number of Americans skipping treatment due to cost concerns.[31] According to one study, approximately 112,000 Medicare beneficiaries will die each year by 2030 due to skipping treatment because of high costs.[32]

THE HIGH DRUG PRICE PROBLEM IS A MONOPOLY PROBLEM

Why are prices so high in the U.S.? The core of the problem is quite simple: drug companies have exclusive rights that permit them to set high prices, and unlike almost every other wealthy country, the U.S. has no concerted system to constrain this monopoly power to ensure fair prices.[33] Companies also engage in anticompetitive conduct that exacerbates the problem.

The drug industry's high prices reflect a specific kind of monopoly problem. Even without industry concentration, government-backed rights create forms of market power that allow companies to set high prices, particularly in a context of widespread insurance and even mandates to cover monopolized products.[34] For example, the U.S. Government allows many kinds of patents on drugs, including not only patents on new molecules or active ingredients, but also patents on new dosages, formulations, and minor modifications of a chemical compound like a salt or isomeric form.[35] All of these patents last 20 years, and allows patentees to exclude others from making, using, importing, or selling the covered inventions. Companies can create "thickets" of such patents, ring-fencing lucrative medicines to forestall competition. Other forms of market exclusivity are also granted at the regulatory interface, such as data exclusivity that prevents generic or biosimilar drug registration based on originator data for a certain number of years.

This is why though most prescriptions in the U.S. are for generic drugs, spending is heavily concentrated on patented medicines. Brand-name drugs, for example, account for three-quarters of drug spending overall.[36] And a small number of newer

---

[29] Jeanne M. Madden, et al., "Affordability of Medical Care Among Medicare Enrollees," *JAMA Health F.,* December 2021, doi:10.1001/jamahealthforum.2021.4104; *see also* Michael Karpman, et al., Urban Institute, *In the Years Before the COVID–19 Pandemic, Nearly 13 Million Adults Delayed or Did Not Get Needed Prescription Drugs Because of Costs* (2021), *https://www.urban.org/research/publication/years-covid-19-pandemic-nearly-13-million-adults-delayed-or-did-not-get-needed-prescription-drugs-because-costs;* Juliette Cubanski et al., Kaiser Family Foundation, *The Financial Burden of Health Care Spending: Larger for Medicare Households Than for Non-Medicare Households* (2018), *https://www.kff.org/fb23909/*.

[30] Beneficiaries who make less than $50,000 per year were twice as likely to delay care as those who make more than $50,000, and those with four or more chronic conditions were twice as likely to delay care as those with one or no chronic conditions. Madden, *supra* note 28, at 6.

[31] "New Poll: Major Spike in Percent of Americans Skipping Medical Treatment Due to Cost," *West Health* (December 14, 2021), *https://www.westhealth.org/press-release/2021-healthcare-in-america-report-2/*. A poll by Gallup and *West Health* found that one-fifth of Americans in 2021 reported negative health consequences after they or a family member delayed care due to cost. The rate of delayed care was comparable between Medicaid beneficiaries (37 percent) and the uninsured (39 percent), and Black adults were twice as likely as White adults to personally know someone who died after delaying their medical care. Although the study did not separately provide results for Medicare beneficiaries, research has generally confirmed that the financial burdens associated with health care are at least as high if not higher among Medicare beneficiaries compared to the general population. *See supra* notes 21–29.

[32] Council for Informed Drug Spending Analysis, *High Drug Prices and Patient Costs: Millions of Lives and Billions of Dollars Lost* (November 18, 2020), *https://www.cidsa.org/publications/xcenda-summary* (CIDSA is a non-partisan group of experts funded by *West Health*).

[33] Aaron S. Kesselheim, Jerry Avorn and Ameet Sarpatwari, "The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform," 316 *JAMA* 858 (2016), *https://doi.org/10.1001/jama.2016.11237.*

[34] Rachel Sachs, "Delinking Reimbursement," 102 *Minnesota Law Review* 2307 (2018) (noting that Federal law also requires that Medicaid and Medicare "cover most, and in many cases all, FDA-approved drugs," and that private insurers are also required to cover many drugs, mandated by the ACA's "essential health benefits" requirement and many State laws).

[35] Amy Kapczynski, Chan Park and Bhaven Sampat, "Polymorphs and Prodrugs and Salts (Oh My!): An Empirical Analysis of 'Secondary' Pharmaceutical Patents," 7 *PLOS ONE* e49470 (2012), *https://doi.org/10.1371/journal.pone.0049470.*

[36] Aaron Kesselheim et al., "The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform," 316 *JAMA* 858 (2016).

medicines without generic competition comprise the bulk of our spending. Medicare offers an example. Just 7 percent of drugs in Medicare Part D drive 60 percent of spending.[37] Medicare, of course, is forbidden by law from negotiating for lower prices for medicines.

Although the pharmaceutical industry has historically argued that exclusive rights and high prices are needed to compensate for R&D, there is growing recognition that prices are not set in relation to R&D.[38] Rather, prices are set in relation to what market can bear, and that turns not on R&D costs but on the amount of market power a company can exercise.

So, we see that the largest pharmaceutical companies spend significantly more on marketing than they do on R&D even during a global pandemic, with some exceeding R&D twofold.[39] We see old drugs—with no new innovation, like analogue insulins—rising in price. And we see companies engaging in exploitative and anticompetitive conduct, lining their pockets not by investing in breakthrough innovations, but by investing in patent lawyers to engage in "life-cycle management" by creating patent thickets rather than investing in new drugs.[40]

We know also that it is government funding, not industry funding, that is disproportionately likely to lead to breakthrough medicines.[41] The unfortunately reality is that high drug prices are not guaranteeing us investment in the right kind of innovation.[42] The silver lining is that it is possible to act on high prices without undermining innovation, and indeed while *improving* innovation incentives by ensuring that only real innovation is rewarded.

---

[37] Juliette Cubanski, et al., Kaiser Family Foundation, *Relatively Few Drugs Account for a Large Share of Medicare Prescription Drug Spending* (2021), *https://www.kff.org/medicare/issue-brief/relatively-few-drugs-account-for-a-large-share-of-medicare-prescription-drug-spending/*.

[38] *See, e.g.,* U.S. Department of Health and Human Services, *Prescription Drugs: Innovation, Spending, and Patient Access* (2016), *https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//192456/DrugPricingRTC2016.pdf* ("Drug manufacturers often point to high drug development costs as a justification for high drug prices and understanding the R&D costs and time to develop a new drug is important. However, the relationship between R&D costs and drug prices is subject to a number of misconceptions. In reality, the prices charged for drugs are unrelated to their development costs. Drug manufacturers set prices to maximize profits. At the time of marketing, R&D costs have already occurred and do not affect the calculation of a profit-maximizing price.").

[39] AHIP, *New Study: In the Midst of COVID–19 Crisis, 7 Out of 10 Big Pharma Companies Spent More on Sales and Marketing Than R&D* (2021), *https://www.ahip.org/news/articles/new-study-in-the-midst-of-covid-19-crisis-7-out-of-10-big-pharma-companies-spent-more-on-sales-and-marketing-than-r-d.*

[40] Kerstin N. Vokinger et al., "Strategies That Delay Market Entry of Generic Drugs," 177 *JAMA Internal Medicine* 1665 (2017).

[41] *See* Aaron S. Kesselheim, Yongtian Tina Tan and Jerry Avorn, "The Roles of Academia, Rare Diseases, and Repurposing in the Development of the Most Transformative Drugs," 34 *Health Affairs* 286 (2015) ("We studied the developmental histories of 26 drugs or drug classes approved by the Food and Drug Administration between 1984 and 2009 that were judged by expert physicians to be transformative (in two cases, the first drug in a transformative class was approved before 1984). Most of the 26 were first approved early in the study period; only four were approved in 2000 or later. Many were based on discoveries made by academic researchers who were supported by Federal Government funding. Others were jointly developed in both publicly funded and commercial institutions; the fewest number of drugs had originated solely within pharmaceutical industry research programs."); Aaron S. Kesselheim, "Public Sector Financial Support for Late Stage Discovery of New Drugs in the United States: Cohort Study," 367 *BMJ* 1 (2019), *https://www.bmj.com/content/bmj/367/bmj.l5766.full.pdf;* Ekaterina Cleary, Matthew Jackson and Fred Ledley, *Government as the First Investor in Biopharmaceutical Innovation: Evidence From New Drug Approvals 2010–2019* (Institute for New Economic Thinking, Working Paper No. 133, 2020), *https://www.ineteconomics.org/research/research-papers/government-as-the-first-investor-in-biopharmaceutical-innovation-evidence-from-new-drug-approvals-2010-2019.*

[42] Unlike government, which funds research in order promote public health, corporations assign their research funds based on marketability and profit, rather than therapeutic benefits. As a result, research in the most important biomedical sectors is chronically underfunded. *See* Massimo Florio, "Biomed Europa: After the Coronavirus, a Public Infrastructure to Overcome the Pharmaceutical Oligopoly," 92 *Annals of Public Cooperation Economics* 387, 388 (2021); *see also* Son Le, et al., "Reaching for Mediocrity: Competition and Stagnation in Pharmaceutical Innovation," 64 *International Review of Law and Economics* 1 (2020) (describing substantial underinvestment by private firms in developing novel drugs, but overinvestment in marginal, "me too" drugs).

PATENT ABUSE: PATENT THICKETS AND PAY-FOR-DELAY

Consider the problem of "patent thickets." Patent thickets occur when pharmaceutical firms file numerous patents on an existing product in order to create barriers to competition and to extend effective patent life. In a study of all new molecular entities approved in the U.S. from 1998 to 2005, colleagues and I showed that "secondary" patents (for example, on formulations, methods of treatment, or isomers) are extremely common in the industry—in fact, more common than patents on chemical compounds.[43] We also showed that where both compound patents and secondary patents existed, the latter added between 4 and 5 years of nominal additional patent term.[44] A more recent study looked at biologic drugs litigated from 2010 to 2020 and found that only 6 percent of patents on biologics covered innovative new molecules. Most others instead covered associated manufacturing processes, alternative uses of a medicine, and formulations.[45]

One of the most infamous examples of patent thicketing is Humira, the world's best-selling drug. AbbVie, the drug's manufacturer, filed over 130 patents related to the drug's manufacturing methods and formulations just a few years before the patent's expiration date.[46] Conveniently, AbbVie tripled the price of Humira, a drug used to treat arthritis, between 2006 and 2017.[47] This is not a unique tactic. One study found that on average, across the top twelve grossing drugs in the United States, there are 125 patent applications filed per drug, with associated prices increasing by 68 percent between 2012 and 2018.[48]

The same study finding extreme patent thickets around the top twelve grossing drugs in the United states also observed "38 years of attempted patent protection blocking generic competition sought by drugmakers for each of these top grossing drugs."[49] These anticompetitive measures help prop up prices, especially of the most profitable drugs where this kind of evergreening is the most common.[50]

Pay-for-delay tactics are another form of anticompetitive practice that increase drug prices. Reverse payment patent settlements, the most frequently cited example of pay-for-delay tactics, take place during patent litigation when generic firms decide to abstain from entering a market in exchange for large sums of money from a brand-name manufacturer. This benefits the patent-holder by staving off open competition for a period, and the patent holder then turns over some of the spoils to the generic company. The ulcer drug Zantac provides an example. Glaxo—the drug's manufacturer—agreed to pay the generic firm seeking entry a large, undisclosed sum (some estimate a number upwards of $100 million) in exchange for an extended period without competition which, at the time, yielded Glaxo $2 billion a year.[51]

The Federal Trade Commission estimated in 2010 that "pay-for-delay agreements would cost consumers $35 billion over the next 10 years."[52] More recent estimates have suggested that pay-for-delay tactics deals cost roughly $26 billion a year.[53] Pharmaceutical companies have also innovated a number of other illegitimate ways to prevent competition, including denying generic manufacturers access to drug samples necessary for bioequivalence testing, misusing risk evaluation and mitigation strategies, and filing citizen petitions with the U.S. Food and Drug Administra-

---

[43] *See* Amy Kapczynski, Chan Park and Bhaven Sampat, *supra* note 34, at 4.

[44] *Id.*

[45] Ed Silverman, "Patent Thickets Are Thwarting U.S. Availability of Lower-Cost Biosimilar Medicines, Study Finds," *STAT News* (January 18, 2022), *https://www.statnews.com/pharmalot/2022/01/18/patent-biosimilar-abbvie-biologic/*.

[46] Patricia Kelmar, U.S. Public Interest Research Group, *Hacking Through Thickets of Drug Patents to Get to Affordable Medicine* (2021), *https://uspirg.org/blogs/blog/usp/hacking-through-thickets-drug-patents-get-affordable-medicine.*

[47] *Id.*

[48] IMAK, *Overpatented, Overpriced: How Excessive Pharmaceutical Patenting Is Extending Monopolies and Driving Up Drug Prices* (2018), *https://www.i-mak.org/wp-content/uploads/2018/08/I-MAK-Overpatented-Overpriced-Report.pdf.*

[49] *Id.* at 2.

[50] The Drug Prices Team, *"Evergreening" Stunts Competition, Costs Consumers and Taxpayers,* Arnold Ventures (September 24, 2020), *https://www.arnoldventures.org/stories/evergreening-stunts-competition-costs-consumers-and-taxpayers.*

[51] C. Scott Hemphill, "Paying for Delay: Pharmaceutical Patent Settlement as a Regulatory Design Problem," 81 *NYU Law Review* 1553, 1568–69 (2006).

[52] Robin Feldman et al., "Pharmaceutical 'Pay-for-Delay' Reexamined: A Dwindling Practice or a Persistent Problem?", 71 *Hastings Law Journal* 959, 961 (2020).

[53] Symposium, "Assessing Strategies to Delay Generic Drug Entry," 11 *NYU Journal of Intellectual Property and Entertainment Law* 60, 71 (2021).

tion (FDA).[54] The 2019 CREATES Act targeted two such strategies, sample blockades and safety protocol filibusters, and shows that concerted congressional action can help curb such activity.[55]

THIS IS "INFLATION" THAT WE KNOW HOW TO ADDRESS

There is a great deal of concern in Washington today about inflation. In closing, it is worth noting that this is fundamentally inflationary environment, and has been for a long time. I'd like to stress two things about inflation in this context.

First, some have cast doubt on the idea that there is a relationship between monopolies and inflation. This is one domain where the link is perfectly clear. Opportunities for monopoly power have increased in recent decades, as exclusive rights have expanded, as firms have innovated new ways to abuse their market power, and as insurer mandates to cover pharmaceuticals have expanded. It is generally agreed that increases in monopoly power will cause increases in prices.

The problem is exacerbated by certain features of this market, including the fact that medicines are essential and often do not have good substitutes, and that third-party payers can both spread costs and obscure price increases (and so interfere with concerted responses and accountability). Intellectual property law is being exploited to allow monopolists to increase real prices without corresponding increases in quality, and without jeopardizing market share.

The only thing that really checks the ability of monopolies to raise drug prices is political pressure, and ultimately the willingness of the government to intervene.[56] This is particularly true when their biggest buyer—Medicare—is barred from even negotiating what it pays.

This is also a sector where inflated prices are causing enormous pain, as described earlier. And yet, for many years—and still, as we sit here today—this chamber has taken no serious action. Why is this not treated as an emergency, given the urgency for people's lives? And given that the government has clear, sector-specific tools that are well mapped out to address the problem? Many would also argue sector-specific approach to inflation is better than taking economy-wide action, for example through the Fed.

We also know how to curb inflation in this sector. The path is extremely well mapped out, particularly when as compared to other sectors of the economy. Other countries have successfully curbed drug prices, implementing many different versions of fair pricing regulation that are well studied. Congress has now had years of legislative hearings, taking evidence about those experiences and considering draft legislation. It is past time to act, to pass serious legislation to curb high drug prices and anti-competitive practices in the industry.

RECOMMENDATIONS

I close with several recommendations. In order to protect the future of the Medicare program, and Medicare beneficiaries, Congress should:

- Pass legislation that curbs high launch prices, by enabling HHS negotiators to establish fair prices, either through negotiation or administratively. Inputs to fair prices should include measures of R&D expenditures, public funding, investment risk, and therapeutic benefit of the drug. These negotiations must be backed by strong enforcement measures, such as the ability to allow generic competitors into the market if a company refuses to sell at the established price.
- Pass legislation to penalize price spikes, to prevent price gouging on existing drugs.

---

[54] Aaron S. Kesselheim, "Strategies That Delay Market Entry of Generic Drugs," 177 *JAMA Internal Medicine* 1665 (2017).

[55] Michael Kades, *The CREATES Act Shows Legislation Can Stop Anticompetitive Pharmaceutical Industry Practices,* Washington Center for Equitable Growth (May 27, 2021), *https://equitablegrowth.org/the-creates-act-shows-legislation-can-stop-anticompetitive-pharmaceutical-industry-practices/*.

[56] *See* Rena M. Conti, "How Do Commercial Insurance Plans Fare Under Proposed Prescription Drug Price Regulation?", *JAMA Health Forum,* December 2021, *https://jamanetwork.com/journals/jama-health-forum/fullarticle/2787467* (explaining why drug companies, despite being monopolists, might not always price their drugs at the profit maximizing level out of the gate in order to reap second-order benefits like public and political goodwill, thereby preserving their ability to hike prices down the road).

- Explore legislation that would curb anti-competitive patent thicketing and that would strengthen rules against pay-for-delay settlement deals that delay generic entry.
- Provide the FTC with more resources and authority to address anticompetitive conduct in this sector.

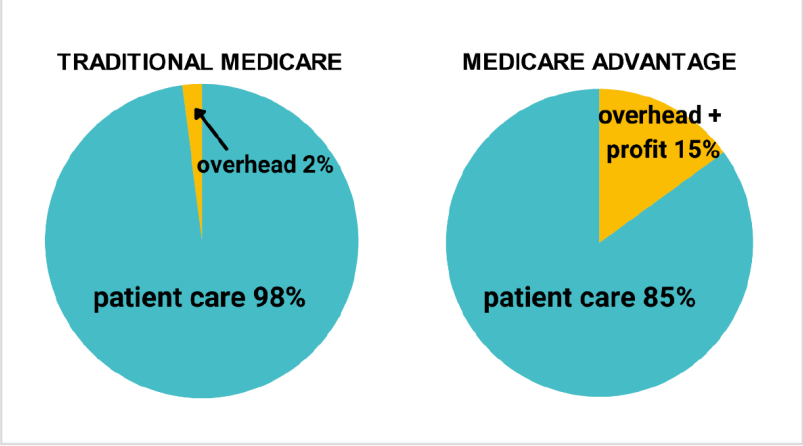
PREPARED STATEMENT OF SUSAN ROGERS, M.D., FACP, PRESIDENT, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PART 1: THE FIRST PHASE OF MEDICARE PRIVATIZATION—MEDICARE ADVANTAGE

To understand how Direct Contracting works and why it threatens Medicare's future, it's important to understand the first wave of traditional Medicare privatization through Medicare Advantage.

Traditional Medicare (TM) reimburses providers directly at a set rate for services provided to beneficiaries (fee-for-service); beneficiaries have free choice of any doctor or hospital. Because of TM's simplicity, the program spends 98 percent of its funds on patient care, with only 2 percent spent on administration.

In contrast, **Medicare Advantage (MA)** is a version of Medicare run mainly by commercial insurers for profit. MA insurers act as middlemen between Medicare and providers: Medicare pays MA insurers via "capitation," a lump-sum payment per enrollee per month. MA insurers then pay providers a fee-for-service for enrollees' care, and keep what they don't spend on care as overhead and profit. Medicare requires MA insurers to spend 85 percent [1] of their revenues on care (called a "medical loss ratio"), keeping the other 15 percent as overhead and profit. **Because of MA insurers' profit and administrative waste, taxpayers spend $321 [2] more per year to cover a senior through an MA plan compared to TM.**



Medicare Advantage is a highly profitable segment for commercial insurers. Gross margins for Medicare Advantage plans averaged $1,608 [3] per enrollee per year between 2016 and 2018, nearly double the average gross margins for individual and group market plans.

---

[1] *https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-through-september-2020/.*
[2] *https://www.kff.org/medicare/press-release/payments-to-medicare-advantage-plans-boosted-medicare-spending-by-7-billion-in-2019.*
[3] *https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-health-insurance-markets-issue-brief/.*

Medicare Advantage insurers maintain these high profits in two ways: (1) maximizing the payments they receive from Medicare, and (2) minimizing what they spend on patient care.

First, MA insurers maximize payments from Medicare by making their enrollees appear sicker than they really are. Medicare's capitation payments to MA insurers are based on each enrollee's "risk score"—the sicker the enrollee, the higher the score and the payment. However, MA insurers engage in a kind of fraud called "upcoding,"[4] exaggerating[5] and even fabricating diagnoses to inflate enrollees' risk scores. Insurers use sophisticated AI software to scan patient records for upcoding opportunities, pay[6] doctors to document additional diagnoses, and even send insurer-employed nurses to seniors' homes[7] to upcode. Some MA insurers now buy provider practices[8] outright, allowing them to control the diagnostic coding process.

Note that risk scores and capitation payments do not account for the actual care provided to the patient, only the number and severity of diagnoses in a patient's record.

Example of patient record, before upcoding

Condition	SCORE
Baseline for Age: 76 yo female	.45
Obesity	0
Type 2 Diabetes	.104
Major Depression	0
Congestive Heart Failure	.323
Asthma	0
Ulcer (unspecified)	0
Cong. Heart Failure*DM	.154
TOTAL RISK SCORE	1.03
Payment to MA insurer	$9,000

Example of patient record, after upcoding

Condition	SCORE
Baseline for Age: 76 yo female	.45
Morbid Obesity	.273
Type 2 Diabetes w/ retinopathy	.318
Major Depression, single ep, mild	.395
Congestive Heart Failure, Class 3	.323
COPD	.328
Ulcer, Stage 3	1.204
Cong. Heart Failure*DM, COPD	.154, .19
TOTAL RISK SCORE	3.63
Payment to MA insurer	$32,000

Fraudulent upcoding caused risk scores of patients in MA plans to be 19 percent higher[9] compared to those in TM; as a result of upcoding, researchers estimate that **Medicare overpaid MA insurers by more than $106 billion**[10] from 2010 through 2019.

Next, MA insurers retain revenues by avoiding payment for costly care. First, MA insurers aggressively market their plans to healthier (*i.e.,* less costly) seniors with perks like gym memberships that would not benefit older or sicker beneficiaries, often called "cherry-picking" enrollees. Then, MA insurers reduce medical expenses by restricting patients to narrow networks of specialists, imposing thousands of dollars in hidden fees for costly care like chemotherapy, and limiting care through pre-authorizations and denials. These barriers to care often force beneficiaries to switch from MA plans back to TM when they require costly or complex care. This type of "lemon-dropping" causes a large percentage of dying patients to switch from MA to TM in their last year of life.

PART 2: THE NEXT PHASE OF MEDICARE PRIVATIZATION—DIRECT CONTRACTING

A majority[11] of seniors and disabled Americans choose traditional Medicare (TM) over Medicare Advantage (MA) because they value the free choice of providers and the power to manage their own care. However, under the Medicare Direct Contracting (DC) pilot program, millions of beneficiaries who actively chose TM are

---

[4] *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0768.*
[5] *https://pubmed.ncbi.nlm.nih.gov/32925467/.*
[6] *http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf#page=410.*
[7] *http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf#page=410.*
[8] *https://www.healthaffairs.org/do/10.1377/hblog20210927.6239/full/.*
[9] *https://www.npr.org/sections/health-shots/2021/11/11/1054281885/medicare-advantage-overcharges-exploding.*
[10] *https://khn.org/news/article/medicare-advantage-overpayments-cost-taxpayers-billions-researcher-says/.*
[11] *https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/.*

being automatically enrolled into third-party Direct Contracting Entities (DCEs) without their full knowledge or consent.

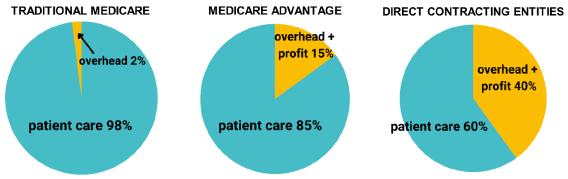
Even though DC represents a radical change to TM, most beneficiaires—and, until recently, most members of Congress—have never heard of the DC program, and for good reason. The program was created by the Center for Medicare and Medicaid Services (CMS) "Innovation Center,"[12] which was established by the Affordable Care Act in 2010 to test and implement health payment models *without* congressional approval.

Direct Contracting Business Model

The DC pilot program was developed in 2019 during the Trump administration to further privatize traditional Medicare using some of the same elements as Medicare Advantage, such as capitation payments, risk scores, and a profit-based incentive model. Instead of paying doctors and hospitals directly for seniors' care, Medicare gives DCE middlemen a monthly capitation payment to cover a defined portion of each beneficiary's medical expenses. DCEs are then allowed to keep what they don't pay for in health services, a dangerous financial incentive to restrict and ration seniors' care.

There are different models of DCEs, but they all assume some level of "risk sharing," meaning they keep as profit some or all of what they don't spend on care, or take as a loss some or all of what they spend beyond the capitation payment. The DC payment model is similar to MA in that it **incentivizes DCEs to both increase capitation payments by "upcoding" diagnoses, and to decrease expenses by spending as little as possible on patient care.**

The opportunity for profit is much higher in the DC program compared to MA, where insurers are required to spend 85 percent of their revenues on patient care (called a "medical loss ratio"), and are allowed to keep up to 15 percent of Medicare's payments to them as profit and overhead. However, DCEs don't have such guardrails on health spending. In fact, former CMS officials estimate that **DCEs have an "implicit but irrelevant" medical loss ratio requirement of approximately 60 percent,**[13] meaning they are expected to keep approximately 40 percent of what Medicare pays them as profit and overhead.



There are three types of DCEs: Geographic (GEOs), Professional Direct Contracting, and Global Direct Contracting.

1. **Geographic DCEs (GEOs)** are the most extreme of the three models, with the potential to fully privatize traditional Medicare. Under the GEO model, every TM beneficiary living in a number of large geographic regions is auto-assigned[14] into a DCE, with no right to opt out. GEO DCEs assume 100-percent risk (profits and losses) for a beneficiary's medical services. Under pressure from health-care advocates, the GEO pilot was paused by the Biden administration in early 2021.
2. **Professional DCEs** assume a 50 percent risk-sharing arrangement with CMS, and can also participate in "primary care capitation,"[15] receiving a monthly payment from CMS for primary care services only, at an amount determined by each enrollee's risk score.

---

[12] *https://innovation.cms.gov/.*
[13] *https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/.*
[14] *https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/.*
[15] *https://www.aafp.org/about/policies/all/capitation-primary-care.html.*

3. **Global DCEs** assume 100-percent risk via two payment options from CMS: primary care capitation or total care capitation, for all services provided by the DCE and its contracted "preferred" providers.

Virtually any type of company can apply to be a DCE, including commercial insurers, venture capital investors, and even dialysis centers. Applicants are approved [16] by CMS without input from Congress or other elected officials.

At the end of 2021, the pilot involved 53 DCEs [17] in 38 States, DC, and Puerto Rico, potentially covering 30 million [18] of the 36 million TM beneficiaries. Of the 53 DCEs, 39 are "global" (100-percent risk sharing), and 14 are "professional" (50-percent risk sharing). A majority of DCEs (28 of 53 total [19]) are controlled by investors—not providers. Of the investor-owned DCEs, six are owned by four different MA insurers, and are approved to operate in 19 States, with potential access to more than 20 million [20] TM beneficiaries.

Experts predict [21] that MA insurers will dominate the DCE segment, given MA's national network and experience with capitation, risk-sharing, and upcoding schemes.

Impact on Patient Choice

TM beneficiaries are "aligned" to DCEs in two ways. First, DCEs are allowed to proactively market to seniors, asking TM beneficiaries to voluntarily enroll. More commonly, Medicare will "auto-align" beneficiaries to a DCE based on the beneficiaries' existing relationship with a DCE-affiliated primary care provider. To auto-align beneficiaries, Medicare will annually conduct "prospective alignment,"[22] automatically searching 2 years of each TM beneficiary's claims history—without their knowledge or consent—for any recent encounters with a DCE-affiliated provider. **TM members are allowed to opt out of having their data shared with the DCE (though few, if any, would know of their right to do this), but cannot opt out of being aligned into the DCE.**

If a senior is auto-aligned into a DCE, **their only way to remove themselves from the DCE is to change primary care providers.** Changing primary care providers is a difficult task for most patients, but is especially challenging for medically vulnerable patients and those residing in rural or other underserved areas. In addition, asking seniors to change providers undermines Traditional Medicare's promise of free choice in providers.

Currently, DCE-aligned patients are allowed to get medical care outside of their DCE's network (*i.e.,* from a specialist); those out-of-network providers are then paid directly by Medicare at Medicare-contracted rates, and CMS ultimately reconciles those costs back to the patient's DCE. **Therefore, the DCE has a financial incentive to steer patients to specialist providers within the DCE's network, where the DCE has direct influence over the payment model.**

DCEs are expected to have a big impact on physician practices. Given that alignment into a DCE is determined by a TM member's primary care physician, DCEs are actively recruiting medical groups and physicians into their network. Researchers have documented [23] a quiet explosion of Wall Street investment in primary care practices, which historically produce little or no profit. But investors who understand the DCE model—including the upcoding game perfected by Medicare Advantage—know that **owning a DCE physician practice could result in massive profits over time.** And DCEs owned by commercial insurers may try to move enrollees into their MA plans.

Status of the Direct Contracting Pilot Program

The DC program officially began on April 1, 2021 and the Global and Professional pilots are scheduled to run for 6 years.[24] CMS also allowed an additional, previously approved cohort of DCEs to launch in early 2022. The agency has—for now—paused acceptance of new applicants, but may open it up again for the 2022–23 cohort.

---

[16] *https://innovation.cms.gov/media/document/gpdc-model-general-faqs.*
[17] *https://innovation.cms.gov/media/document/gpdc-model-participant-announcement.*
[18] *https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/.*
[19] *https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/.*
[20] *https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/.*
[21] *https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/.*
[22] *https://innovation.cms.gov/media/document/dc-financial-op-guide-overview.*
[23] *https://www.healthaffairs.org/do/10.1377/hblog20210927.6239/full/.*
[24] *https://innovation.cms.gov/media/document/gpdc-model-general-faqs.*

The CMS Innovation Center recently said[25] that, "All Medicare FFS [traditional Medicare] beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030," signaling their intention to rapidly expand the DCE program to cover all TM beneficiaries in the next 8 years.

Dr. Donald Berwick, a former Administrator of the Centers for Medicare and Medicaid Services, and Dr. Richard Gilfillan, former Deputy Administrator of the Centers for Medicare and Medicaid Services and Director of the Center for Medicare and Medicaid Innovation, together published a pair of articles for the journal *Health Affairs* explaining[26] the dangers of the DC program, prompting a national debate on direct contracting.

In recent months, a grassroots movement[27] of physicians, seniors, and community and health advocacy groups have called for an immediate end to the DC program. Advocates argue that, if left unchecked, DC could essentially privatize traditional Medicare without the consent of its own enrollees, or even a vote by Congress.

In January, 54 members of Congress sent a letter[28] to Health and Human Services Secretary Xavier Becerra demanding an end to the DC program, stating that, "This model disrupts the sanctity of traditionally public Medicare benefits by giving control of beneficiary care to private interests."

Physicians for a National Health Program welcomes a robust debate not only on Medicare Direct Contracting but on the role of profit-seeking middlemen in any publicly funded health program. Medicare's other privatization project—Medicare Advantage—has demonstrated that injecting a profit motive into patient care doesn't save money or improve care; instead it leads to higher costs for taxpayers and more barriers to care for patients.

Traditional Medicare is our Nation's most important and popular health-care program; it has proven its value for more than half a century as a lifeline for America's seniors and younger adults living with disabilities. **Medicare is not a playground for Wall Street investors.** Instead of selling it off to the highest bidder through the MA and DC programs, we call on Congress to strengthen Medicare by improving its benefits, eliminating costs for beneficiaries, and expanding it to cover everyone in the U.S.

PREPARED STATEMENT OF HON. ELIZABETH WARREN,
A U.S. SENATOR FROM MASSACHUSETTS

Good afternoon, and welcome to today's hearing before the Subcommittee on Fiscal Responsibility and Economic Growth.

I'm pleased to be working with Ranking Member Cassidy on the hearing "The Hospital Insurance Trust Fund and the Future of Medicare Financing." That title may sound a little dry, so let me be more direct: this hearing is about Medicare finances—both how to strengthen the current system and how to pay for expanded coverage to include vision, dental, and hearing.

The short version is this: the Medicare system is hemorrhaging money on scams and frauds. It is critical that we stop the flow, and, if we do, the system will have more than enough money to operate at its current level and increase coverage.

Where do we begin? Well, how about with giant drug manufacturers. In 2019, total Medicare spending on prescription drugs was $220 billion. Since Medicare is a very high-volume buyer, you would think that the Medicare program would be getting a great deal on pricing. But you would be wrong. Because Medicare cannot negotiate prices, drug companies are able to rake in billions in profits.

Now, that's bad enough. But the drug companies have more ways to juice their profits. They use anticompetitive tactics like pay-for-delay, product hopping, and patent thickening—all while antitrust regulators turn a blind eye. It's enough to gag a maggot.

There's so much we could do to improve Medicare finances. For example, we could save Medicare as much as $130 billion over 10 years just by strengthening enforcement of our antitrust laws and ending one—just one—type of the industry ripoffs.

---

[25] *https://innovation.cms.gov/media/document/cmmi-strategy-webinar-slides.*
[26] *https://www.healthaffairs.org/do/10.1377/hblog20210927.6239/full/.*
[27] *https://pnhp.org/direct-contracting-entities-handing-traditional-medicare-to-wall-street/.*
[28] *https://jayapal.house.gov/wp-content/uploads/2022/01/Medicare-DCE-Letter.pdf.*

Or consider another option: we could rein in greedy private insurers that take advantage of the Medicare Advantage program. Now, Medicare Advantage was a backdoor effort to privatize the Medicare program. It was built on vague promises of cost savings. But instead, it has cost Medicare almost $150 billion extra over the past 12 years, because greedy private insurers are gaming the program's rules—including its risk adjustment process, its benchmark policy, and its quality bonus program—all to squeeze more money out of Medicare and to drive up the costs for taxpayers. Medicare could save nearly $800 billion over 10 years just by ending these scams.

Together, just those few changes alone would save Medicare over $900 billion over 10 years. And just to put that in perspective, the estimated shortfall in the hospital insurance trust fund is $517 billion between 2026 and 2031, and the cost of extending Medicare coverage to include dental, vision, and hearing to the program is just under $360 billion. In other words, we don't need to cut Medicare benefits, we need to cut out the scams that are bringing Medicare down.

The number of corporate vultures hoping to feed on Medicare continues to grow. Even today in the Biden administration, CMS has invited the same insurers that are already scamming Medicare and dozens of new investor-owned organizations to cover traditional Medicare beneficiaries through a new privatized Direct Contracting model that lets them pocket, get this, as much as 40 percent in profits. This invites fiscal disaster, and I hope this administration will reverse this decision.

Yes, we need to make changes to Medicare, but not the cuts and privatization that my Republican colleagues have sought in past efforts to, quote, "reform" Medicare. No. Instead of undermining the system and the benefits that we deliver, we need to crack down on greedy drug manufacturers, on private insurers, and on private equity firms. We need drug price negotiation, and we need better oversight of the Medicare Advantage program so that for every dollar spent, a Medicare beneficiary actually gets a dollar's worth of value. And with more than $900 billion that we could save, we need to expand Medicare coverage to include dental, vision, and hearing benefits for all of our seniors and people with disabilities who are part of the program. That is how we build a healthier America.

Now, I look forward today to discussing these issues. I appreciate all of our witnesses who are joining us today, and I look forward to hearing about their experiences and insights.

COMMUNICATIONS

AARP
601 E St., NW
Washington, DC 20004
(888) 687–2277

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the Senate Finance Subcommittee on Fiscal Responsibility and Economic Growth's bipartisan effort to examine the Medicare Part A Hospital Insurance Trust Fund and the future of Medicare financing. Medicare faces long-term financial challenges that must be addressed. The 2021 Medicare Trustees' Report estimates that the Hospital Insurance (HI) Trust Fund, which funds Part A and is mainly financed by payroll taxes, will be solvent until 2026. Continued increases in medical costs, rapid changes in medical technology, and an aging population—which will add 21 million enrollees to the program by 2030—require that we consider policies to secure Medicare for future years. Medicare must remain a strong, broadly supported social insurance program so that it can continue to provide critically needed benefits to protect current and future generations.

It should be noted that HI Trust Fund insolvency means that Medicare will not be able to *fully* pay for the services financed by Part A; it does not mean Medicare is "going broke" or running out of money. In 2026, current projections indicate that the Trust Fund will still be able to cover over 90 percent of Part A billed services. Medicare Part B and Part D will continue to be fully funded by the Supplemental Medical Insurance (SMI) Trust Fund, which is financed through general revenues and premiums. While we must strive to avoid HI insolvency, this must be done through responsible reforms rather than reductions to Medicare benefits.

As described in AARP's *Medicare Financial Outlook: What Do Trust Fund Solvency Projections Mean?,*[1] throughout Medicare's history, Congress has enacted numerous policy changes that have affected the Trust Fund by reducing Medicare's spending compared with previous projections. Other policy changes have repeatedly extended the Trust Fund's solvency by expanding the Trust Fund's revenue. Policymakers should again look to similar policy approaches to address solvency challenges.

Past experience shows that a combination of policy interventions—rather than one single solution—can substantially improve Trust Fund solvency. Previous Medicare adjustments typically included several policy modifications implemented together to improve Trust Fund projections over time (reflecting a combination of Medicare policies as well as economic changes not related to Medicare). For example, the Balanced Budget Act of 1997 reduced spending growth by decreasing the annual updates to hospital payments, modifying payment methods for home health care and skilled nursing facilities, and shifting some home health spending from Part A to Part B. In addition, the Act increased Trust Fund income from payroll taxes. As a result, in 1998, the Medicare Trustees' Report projected insolvency to occur in 10 years, up from their projection of only 4 years in the prior year's report.

In a more recent example, the Trustees increased the estimated Part A solvency period by 12 years, reflecting numerous changes enacted in the 2010 Affordable Care Act. These changes reduced spending for hospitals and other Part A services and increased Trust Fund revenue by establishing a higher payroll tax on earnings over a specified amount, beginning in 2013.

---

[1] Komisar, Harriet. *Medicare Financial Outlook: What Do Trust Fund Solvency Projections Mean?* Washington, DC: AARP Public Policy Institute. May 2020. *https://doi.org/10.26419/ppi.00102.001.*

The testing and implementation of new payment innovations and person-centered care pilots and demonstrations have the potential to identify new approaches that, when scaled, could reduce unnecessary spending and slow spending growth. Scaling such approaches could improve the solvency outlook over time and lower the Trustees' current projections.[2] Still, other policy changes may be needed to strengthen the Part A Trust Fund for the future.

The most substantive action Congress can take right now to improve the Medicare program's finances is to address prescription drug pricing. Passing prescription drug reforms, like those contained in the Build Back Better Act, would save nearly all Medicare beneficiaries money in their pocket and save the Medicare program billions of dollars each year. Lower prices, and better health outcomes and reduced hospitalizations resulting from improved medication adherence, would benefit both the HI and SMI Trust Funds.

Congress can also improve Medicare's program-wide finances by addressing Medicare Advantage (MA) payments. AARP believes Medicare payments should be neutral with respect to coverage options. Congress should set and maintain benchmarks upon which MA plan payments are based so they are more in line with Original Medicare costs. As MedPAC has recommended, Congress should periodically evaluate the impact of the MA reimbursement methodology to ensure reasonable private health plan participation in the Medicare program and appropriate Medicare payments to participating plans.

Beyond these immediate improvements, a wide variety of incremental changes in Medicare policy could extend the Trust Fund's solvency. History shows that relatively small payment modifications to slow spending growth can have a significant positive impact on the Trust Fund. Policies to increase Trust Fund revenue that have been adopted numerous times throughout Medicare's history should also be considered again, including raising new revenue or redirecting revenue from existing sources. As has always been the case, sustaining Medicare for the future will require continued attention to reducing unnecessary spending, addressing quality of care improvements and ensuring adequate revenue.

Medicare continues to provide critical health coverage for older Americans, and measures to address Medicare's long-term financial outlook are necessary to protect access to high quality care and prevent simply shifting costs to current and future Medicare beneficiaries. We urge you to work together on the necessary combination of policies to the program's finances and payments to maximize the value of every dollar spent.

Thank you for the opportunity to provide AARP's perspective on improving Medicare's current and future finances. We look forward to working with you to address this important issue and ensure continued access to affordable health benefits for older Americans.

ALLIANCE FOR RETIRED AMERICANS
815 16th Street, NW
Washington, DC 20006
https://retiredamericans.org/

The Alliance for Retired Americans appreciates the opportunity to submit comments to the Senate Committee on Finance Subcommittee on Fiscal Responsibility and Economic Growth regarding the hearing titled, "The Hospital Insurance Trust Fund and the Future of Medicare Financing." The Alliance wholeheartedly supports efforts to eliminate waste and reduce drug costs in order to improve Medicare benefits and the system's finances. We oppose proposals that shift any additional 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, DC, the Alliance and its 39 state chapters work to advance public policy that strengthens the health and retirement security of older Americans.

The August 2021 Medicare Trustees Report projects that the Medicare Part A Hospital Insurance Trust Fund will become insolvent in 2026. After that, the program would be able to pay 91% of the claims. This is unchanged from the previous year

[2] Lind, Keith. *Savings Expected from Slowdown in Medicare Spending.* Washington, DC: AARP Public Policy Institute. February 2017.

despite the COVID–19 pandemic. This hearing focused on a number of ways to reduce Medicare spending to improve its finances and expand its benefits, and we would like to comment on them.

Drug Price Negotiations

It is past time for Congress to pass legislation allowing the Secretary of Health and Human Services to negotiate lower drug prices under Medicare and allowing private insurers to use this pricing.

Americans pay the highest prices in the world for prescription drugs, and prices on hundreds of drugs have already increased by 5% in 2022, far outpacing inflation. Seniors, who take the most prescription drugs to stay healthy, bear the brunt of these prices.

Nearly a quarter of Americans and 20% of seniors report not being able to afford their prescriptions. As a result, millions of Americans report not taking a prescription as prescribed by their doctor and are instead not filling prescriptions, skipping doses, or taking fewer doses than directed.

The prices are not sustainable or justified. The recent Aduhelm debacle shows that there is no justification for such high prices. After initially launching its Alzheimer's drug, Adulhelm at $96,000 a year, Biogen cut its price in half after controversy over the drug approval process and concerns over the safety of the drug resulted in low sales. While drug companies have justified their high launch prices and yearly price increases as needed to fund research and development, the House Oversight and Reform Committee found in a July 2021 Staff Report that the world's leading drug companies spent more on payout to investors than in research and development. Americans also overwhelmingly support allowing the federal government to negotiate lower prices as evidenced by numerous public opinion surveys. A Kaiser Family Foundation poll conducted in October 2021 found over 80% of American adults support drug negotiations, including 95% of Democrats and 71% of Republicans. The Alliance for Retired Americans supports the Medicare drug price provisions in the Build Back Better Act, which would save nearly $300 billion. These savings should be invested back in the Medicare program.

Patent Abuses

Congress should enact legislation to curb patent abuses. Pharmaceutical companies use numerous tactics to extend patent terms, including the use of patent thicket, pay-for-delay agreements, parking exclusivity, evergreening and other measures that reduce competition and keep prices high.

Patent extensions cost the Medicare program billions of dollars. For example, AbbVie Pharmaceutical filed over 250 patents on Humira and used patent thicket—a group of overlapping patents—to extend its patent on the drug. The extension of Abbie's patent from 2016–2019 cost the Medicare program over $2 billion. In addition, since AbbVie's patents on Humira were set to expire in 2017, the company reached an agreement through a pay-for-delay deal with its competitors Novartis and Amgen to delay the entry of those companies' biosimilars in the United States until 2023. That delay agreement is costing American taxpayers $19 billion.

Medicare Advantage

While Medicare Advantage (MA) may be a good alternative for people who do not have a supplemental policy and cannot afford Medicare's co-pays, the program, which was supposed to save money, actually costs taxpayers far more than traditional Medicare.

In 2019 alone, the government paid MA plans $7 billion more than traditional Medicare, and the cost to insure a beneficiary in a MA is $321 per year more than traditional Medicare.

This is due to several factors, including risk adjustment scores, star rated bonus payments and physician upcoding, which occurs when physicians use codes with higher reimbursement levels when diagnosing the severity of their patient's illness. Regardless of the reason, we urge Congress to direct CMS to hold MA plans to the commitments they made.

These higher reimbursement rates also affect every beneficiary, regardless of whether they are enrolled in an MA plan, through higher Medicare Part B premiums.

To strengthen the Medicare System and its long-term solvency, Congress and the federal government must increase oversight of the MA program and stop overpayments.

Medicare Vision, Dental and Hearing Benefits

The Alliance supports expanding Medicare coverage to include vision, dental and hearing. These services are integral to maintaining an individual's health and providing these benefits can reduce costs under Medicare in the long run.

Lack of dental coverage can exacerbate chronic conditions like diabetes, cardiovascular and kidney disease. In 2016, half of all Medicare beneficiaries did not see a dentist, and the 20% that did, spent $1,000 for dental services. A private dental benefit, similar to Medicare Advantage, is not an acceptable alternative. All beneficiaries should receive guaranteed dental benefits, including those on the traditional Medicare program.

Similarly, while Medicare currently provides coverage for hearing and balance exams, it does not cover hearing services and hearing aids. Fifty percent of Americans who are 60 or older have a meaningful hearing impediment. Research has linked hearing loss to falls, dementia, cognitive decline, social isolation, and reduced quality of life. These conditions increase an individual's total out of pocket health spending by an average of $2,500 annually, according to one analysis.

Lastly, Medicare does not cover eyeglasses and contact lenses. It only covers vision services related to certain diseases such as glaucoma, cataracts and diabetes retinopathy. Expanding these services will help improve the quality of life and safety of all beneficiaries.

Cost-Sharing

We were distressed to hear several senators and witnesses discuss increased cost sharing as a way to change beneficiary behavior or utilization of their guaranteed health benefits.

Patients cannot control whether they become ill, and most do not have the medical expertise to make decisions about their care and treatment.

Medical diagnosis and treatment decisions are appropriately made by physicians, not patients today. While some seniors and disabled beneficiaries may possess the medical knowledge and cognitive ability to make decisions about treatment options or when to seek care, many do not. The idea that if beneficiaries had more "skin in the game", they would make smarter choices about their care helping reduce costs to the program is flawed.

Second, most Medicare beneficiaries can't afford to pay more. Contrary to what some in Congress believe, Medicare beneficiaries are not well off and even paying a "little more" in premiums will affect their income security.

Only 5% of Medicare beneficiaries are considered to be higher income—meaning they have incomes of $88,000 or above—and those beneficiaries already pay more for their Part B and Part D premiums.

In 2019, half of all Medicare beneficiaries had annual incomes below $29,650 and one in four had incomes below $17,000. Older adults already spend 14 percent of their income on medical expenses whereas the average American household spends 5% of their income on health care.

Third, while increased cost sharing may initially reduce demand for care and government spending, it would 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.

Premium Support

We were also disappointed to hear the Committee and witnesses discuss premium support. This proposal fundamentally alters the 56-year old Medicare program and threatens to erode the health benefits retirees have earned over a lifetime of work. 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 provides 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.

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

AMERICAN ACADEMY OF ACTUARIES
1850 M Street, NW, Suite 300
Washington, DC 20036
Telephone 202–223–8196
Facsimile 202–872–1948
https://www.actuary.org/homepage

Statement of Rina C. Vertes, MAAA, FSA, Chairperson, Medicare Committee; and Cori E. Uccello, MAAA, FSA, FCA, MPP, Senior Health Fellow

The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

On behalf of the Medicare Committee of the American Academy of Actuaries ("Academy"), we are pleased to provide the following statement for the record on Medicare's financial condition for the Senate Committee on Finance, Subcommittee on Fiscal Responsibility and Economic Growth. We appreciate the Subcommittee's focus on this important issue and allowing us the opportunity to submit our statement, which focuses on the findings of the most recent Medicare Trustees Report, released in 2021.[1] The Trustees Report contains actuarial analysis, methodology, and assumptions for the program.

Each year, the Boards of Trustees of the Federal Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds submit a report to Congress on the Medicare program's financial condition. The program is operated through two trust funds. The HI trust fund (Medicare Part A) pays primarily for inpatient hospital services. The SMI trust fund includes accounts for the Medicare Part B program, which covers physician and outpatient hospital services, and the Medicare Part D program, which covers the prescription drug program.

The Medicare Trustees Report is the primary source of information on the financial status of the Medicare program, and the Academy proudly recognizes the important contribution that members of the actuarial profession have made in preparing the report. Academy members play a vital role in providing information to the public about the important issues surrounding the program's solvency and sustainability.

The Medicare program faces three fundamental financing challenges:

- Income to the HI trust fund is not adequate to fund the HI portion of Medicare benefits;
- Increases in SMI costs increase pressure on beneficiary household budgets and the federal budget; and
- Increases in total Medicare spending threaten the program's sustainability.

The trustees conclude: "The projections in this year's report continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures."

Due to Medicare's critically important role in ensuring that Americans age 65 and older and certain younger adults with permanent disabilities have access to health care, it is important for policymakers to address the challenges that threaten the program's long-term solvency and financial sustainability. The longer corrective measures are delayed, the worse the financial challenges will become and in turn, the greater the burden that is likely to be imposed on beneficiaries and taxpayers.

Given the impending depletion of the HI trust fund in 2026, policymakers are rightly focused on addressing challenges to HI solvency. However, it is important to recognize that assessing Medicare's financial status goes beyond the focus on HI deple-

[1] Our statement reflects information in our September 2021 issue brief, *Medicare's Financial Condition: Beyond Actuarial Balance, https://www.actuary.org/sites/default/files/2021-09/MedTrustees_IB_9.21.pdf.*

tion. Projected increases in SMI expenditures will require significant increases in beneficiary premiums and general revenue contributions. Moreover, Medicare's sustainability challenges go beyond solvency. Sustainability also reflects whether the program is meeting the needs of its beneficiaries—in terms of adequate benefit coverage and affordable out-of-pocket costs—as well as whether it is addressing racial and ethnic health disparities. Policies should aim to ensure that Medicare beneficiaries have access to high-quality health care that is affordable both to them and to the nation as a whole.

Medicare HI Trust Fund Income Falls Short of the Amount Needed To Fund HI Benefits

Medicare's trust funds account for all income and expenditures. The HI and SMI programs operate separate trust funds with different financing mechanisms. General revenues, payroll taxes, premiums, and other income are credited to the trust funds, which are used to pay benefits and administrative costs. Any unused income is required by law to be invested in U.S. government securities for use in future years. In effect, the trust fund assets represent loans to the U.S. Treasury's general fund. The HI trust fund, which pays for hospital services, is funded primarily through earmarked payroll taxes.

According to the projections in the 2021 Medicare Trustees Report, which are based on current law:

- **HI expenditures are projected to exceed HI revenues.** After experiencing small surpluses in 2016 and 2017, a deficit returned in 2018, 2019, and 2020. The large deficit in 2020 was mostly due to accelerated and advance payments to providers from the trust fund; these payments will be repaid to the trust fund over the next several years, which will lead to a much smaller deficit in 2021 and a surplus in 2022. Deficits are projected to return in 2023 and persist for the remainder of the projection period. As a result, the HI trust fund assets will need to be redeemed. When the federal government is experiencing unified budget deficits, funding the redemptions requires that additional money be borrowed from the public, thereby increasing the federal deficit and debt.
- **The HI trust fund is projected to be depleted in 2026.** At that time, tax revenues are projected to cover only 91% of program costs, with the share declining to 78% in 2045 and then increasing to 91% in 2095. There is no current provision allowing for general fund transfers to cover HI expenditures in excess of dedicated revenues.
- **The projected HI deficit over the next 75 years is 0.77% of taxable payroll.** Eliminating this deficit would require an immediate 27% increase in standard payroll taxes or an immediate 16% reduction in expenditures—or some combination of the two. Delaying action would require more severe changes in the future.

The trustees acknowledge that the estimates based on current-law projections could understate the seriousness of Medicare's financial condition, because actual Medicare expenses might exceed current-law estimates. In particular, the trustees and the chief actuary point to scheduled reductions in provider payments that may not occur. Current law requires downward adjustments in payment updates for most non-physician providers to reflect productivity improvements; these adjustments might not be sustainable in the long term. Current law also requires updates for physician services that are not expected to keep up with physician costs. In the Statement of Actuarial Opinion that accompanies the report, the chief actuary of the Centers for Medicare & Medicaid Services (CMS) specifically states, "Should these price updates prove to be inadequate, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law in this report."

At the request of the trustees, the CMS Office of the Actuary developed an alternative analysis that provides an illustration of the potential understatement of current-law Medicare cost projections if the productivity adjustments were phased down gradually beginning in 2028 and physician updates were more consistent with cost growth. Although the illustrative alternative projections are not intended to be interpreted as the official best estimates of future Medicare costs, they do, as noted in the Trustees Report, "help illustrate and quantify the potential magnitude of the cost understatement."

Under the alternative scenario, the HI trust fund still would be depleted in 2026. However, the projected deficit over the next 75 years would be 1.61% of taxable payroll—compared to 0.77% under current law. Eliminating this deficit would require an immediate 55% increase in standard payroll taxes or a 29% reduction in expenditures—or some combination of the two.

Increases in SMI Costs Increase Pressure on Beneficiary Household Budgets and the Federal Budget

The SMI trust fund includes accounts for the Medicare Part B program, which covers physician and outpatient hospital services, and the Medicare Part D program, which covers the prescription drug program. Approximately one-quarter of SMI spending is financed through beneficiary premiums, with federal general tax revenues covering the remaining three-quarters.[2]

The SMI trust fund is expected to remain solvent due to its financing being reset each year to meet projected future costs. As a result, increases in SMI costs will require increases in beneficiary premiums and general revenue contributions. Increases in general revenue contributions will put more pressure on the federal budget. SMI general revenue funding is scheduled to nearly double from 1.8% of gross domestic product (GDP) in 2021 to 3.1% in 2095.

Premium increases similarly will increase the burden on beneficiaries, especially when considered in conjunction with increasing beneficiary cost-sharing expenses. The average beneficiary expenses (premiums and cost-sharing) for parts B and D combined are currently nearly one-quarter of the average Social Security benefit. These expenses are projected to increase to 40% of the average Social Security benefit by 2095. These expenses do not include cost-sharing under Part A.

The 2021 Medicare Trustees Report projects that total SMI spending will continue to grow faster than GDP. The total spending will increase from 2.5% of GDP in 2021 to 3.2% of GDP in 2030 and to 4.4% of GDP in 2095.

Spending under the illustrative alternative analysis would be higher, especially in the long term, reflecting the phase-down of productivity adjustments for nonphysician provider payments and higher physician updates in the long range. SMI spending projected in the alternative analysis would increase from 2.5% of GDP in 2021 to 3.2% of GDP in 2030 and to 5.5% of GDP in 2095.

Increases in Total Medicare Spending Threaten the Program's Sustainability

A broader issue related to Medicare's financial condition is whether the economy can sustain Medicare spending in the long run. To help gauge the future sustainability of the Medicare program, the trustees consider the share of GDP that will be consumed by Medicare. With Medicare spending expected to continue growing faster than GDP, greater shares of the economic growth will be devoted to Medicare over time, meaning smaller shares of the economy will be available for other priorities.

Under current law, Medicare expenditures as a percentage of GDP will grow from 4.0% of GDP in 2020 to 6.5% of GDP in 2095. However, under the CMS Office of the Actuary alternative scenario, total Medicare expenditures would increase to 8.5% of GDP in 2095.

Table 1: Total Medicare Expenditures as a Percent of GDP

Calendar Year	2021 Report	2021 Alternative Projection
2020	4.0	4.0
2030	5.1	5.1
2040	6.1	6.2
2050	6.2	6.7
2060	6.3	7.1
2070	6.5	7.7
2080	6.6	8.2

[2] Premiums for Medicare parts B and D are income-related. Standard premiums are set to cover approximately 25% of program costs. Higher-income beneficiaries pay higher premiums, ranging from 35% of program costs to 85% of program costs.

Many Part D beneficiaries will receive low-income premium subsidies, lowering their premiums below 25% of program costs. In the aggregate, beneficiary premiums will cover only about 15% of total Part D costs in 2021. State payments on behalf of certain beneficiaries will cover about 10% of costs and general revenues will cover the remaining 73% of costs.

Table 1: Total Medicare Expenditures as a Percent of GDP—Continued

Calendar Year	2021 Report	2021 Alternative Projection
2090	6.5	8.4
2095	6.5	8.5

Source: 2021 Medicare Trustees Report, CMS Office of the Actuary

Conclusion

Consistent with prior trustees reports, the 2021 Medicare Trustees Report stresses the serious financial challenges facing the Medicare program. The HI trust fund is projected to be depleted in 2026. Medicare spending is projected to grow faster than the economy—increasing the pressure on beneficiary household budgets and the federal budget and threatening the program's sustainability.

As noted by the trustees, Medicare's financial challenges could be more severe than projected under current-law assumptions. The report's Medicare spending projections are considered understated to the extent that the Affordable Care Act's provisions for downward adjustments in non-physician provider payment updates to reflect productivity improvements and long-range physician payment updates being held below physician costs are unsustainable in the long term. If Medicare projections are calculated using assumptions that the productivity adjustments are phased down and physician updates are more in line with their costs, Medicare's financial condition is shown to be even worse than under the projected baseline.

The trustees note the urgency of addressing Medicare's financial challenges, stating:

> The Board of Trustees believes that solutions can and must be found to ensure the financial integrity of HI in the short and long term and to reduce the rate of growth in Medicare costs through viable means. The sooner the solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations and behavior. The Board recommends that Congress and the executive branch work together with a sense of urgency to address these challenges.

Medicare's challenges are not solely financial. Medicare beneficiaries are a diverse segment of the broader population with diverse health care needs, and certain beneficiary populations—such as those with a disability or multiple chronic conditions—are particularly vulnerable to having high health care needs. Many beneficiaries have limited resources to rely upon should they be faced with high out-of-pocket health costs. Aside from the addition of the prescription drug program (Medicare Part D) in 2006, Medicare's fee-for-service benefit package has remained mostly unchanged; some services are not covered and beneficiary out-of-pocket costs are not capped. Therefore, any changes aiming to improve Medicare's financial condition should be considered in light of how the changes would impact the program's ability to meet the health care needs of beneficiaries and whether the changes would encourage beneficiaries to seek cost-effective care.

Changes are needed to improve Medicare's solvency and sustainability. Delaying corrective measures would increase the burden that might be imposed on beneficiaries and taxpayers. Any changes aiming to improve Medicare's financial condition should be considered in light of how they would impact the program's ability to meet the health care needs of beneficiaries.

AMERICAN MEDICAL ASSOCIATION ET AL.

The undersigned organizations write to express our collective support for value-based payment arrangements and alternative payment models (APMs) as a means to help prolong the solvency of the Medicare trust fund. According to the most recent Medicare Trustees' Report to Congress, Medicare program assets will be depleted by 2026.[1] This should sound the alarm to Congress and be a reason to update existing law to both encourage new providers to enter into APMs and keep existing providers participating in these models. We offer explanations below as to why Con-

[1] *https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf.*

gress should promote value-based care and offer recommendations for how that can be done.

To avoid depleting resources and prolong the Medicare trust fund, Congress in 2010 created the Medicare Shared Savings Program and Center for Medicare and Medicaid Innovation (CMMI) as part of the Patient Protection and Affordable Care Act. In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) to promote participation in the Shared Savings Program and other APMs created by CMMI. The overall goals of these two laws were to foster a value-based payment system in health care where providers would be incentivized to provide higher quality care at a lower cost.

So far, value-based care is taking root in our health care system, improving patient care and successfully bending the cost curve. The Centers for Medicare and Medicaid Services (CMS) estimates that Medicare Part A and B spending will grow by approximately 0.7 percent below the rate of inflation between 2021 and 2030.[2] This is a positive sign that recent payment reform efforts have taken hold. Since 2012, accountable care organizations (ACOs) have saved Medicare $13.3 billion in gross savings and $4.7 billion in net savings.[3] While that may sound small in comparison to Medicare's overall spending, data from the Medicare Payment Advisory Commission, researchers at Harvard University, and the analytic firm Dobson DaVanzo and Associates show that ACOs are lowering Medicare spending annually by 1 percent to 2 percent.[4, 5, 6] Knowing Medicare Parts A and B cost $636 billion in 2018, a 2 percent reduction in spending would save nearly $200 billion when compounded over a decade, assuming Medicare spending would grow at 4.5 percent per year without ACOs.[7]

Further evidence that ACOs lower spending comes from the impact analysis of the proposed "Pathways to Success" rule in August 2018, in which the CMS Actuary used claims data to look at spending in ACO markets versus non-ACO markets. The agency estimated the overall impact of ACOs, including "spillover effects" on Medicare spending outside of the ACO program, lowered spending by $1.8–$4.2 billion in 2016 alone.[8] When ACOs lower spending across the fee-for-service system, this also lowers payments to Medicare Advantage plans since those payments are based, in part, on fee-for-service spending.

We also know value-based payment models improve quality. In an August 2017 report, the HHS Inspector General reported that in the first three years of MSSP ACOs improved their performance on 82 percent of the individual quality measures compared to their baseline.[9] After the first 3 years 98 percent of ACOs met or exceeded quality standards. In the same report the Inspector General found that ACOs outperformed fee-for-service providers on 81 percent of quality measures. A study published in the January 2017 issue of Health Affairs found that Medicare ACOs lowered hospital readmissions faster than hospitals not affiliated with an ACO.[10]

APMs, including ACOs, uphold patient rights and regularly evaluate patient satisfaction. Importantly, patients maintain their freedom of choice within traditional Medicare, allowing them to see any willing provider. In ACO models, there are no networks or prior authorization. In fact, patients in many APMs receive more benefits under traditional Medicare such as home visits for care management or post-hospital care, cost sharing support, and chronic disease management rewards. Often, patients must be notified they are being seen by a provider practicing in an APM. Providers in APMs are also held to quality measures to ensure the best patient care and incentive payments can't be received without hitting a threshold for high-quality care.

The committee should be focused on leveraging knowledge gained over the last decade of work in value-based payment to promote a more fiscally sustainable health system. APMs focus on value over volume with a commitment to driving wellness

---

[2] *https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf.*
[3] *https://www.naacos.com/highlights-of-the-2020-medicare-aco-program-results.*
[4] *https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch6_medpac_reporttocongress_sec.pdf.*
[5] *https://www.nejm.org/doi/full/10.1056/NEJMsa1803388.*
[6] *https://www.naacos.com/studyofmsspsavings2012-2015.*
[7] *https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/.*
[8] *https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-17101.pdf.*
[9] *https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp.*
[10] *https://www.commonwealthfund.org/publications/journal-article/2017/jan/aco-affiliated-hospitals-reduced-rehospitalizations-skilled.*

and whole-person care. Providers in APMs place a premium on identifying high-need patients, with an emphasis on delivering proactive, preventive care, chronic disease management, care management, and better transitions of care along with a myriad of other tactics that yield better patient outcomes.

We encourage the Committee to consider the bipartisan Value in Health Care Act (H.R. 4587), which would go a long way to address incentives for APM participation.[11] The bill would increase shared savings rates for ACOs to restore them to the levels when the MSSP was launched, modify risk adjustment to be more realistic and better reflect factors participants encounter, remove the arbitrary high and low revenue ACO distinction that creates an inequitable path to risk, remove ACO beneficiaries from the regional benchmark to ensure ACOs are not penalized as they achieve savings for their assigned populations, among other changes.

Importantly, it would also extend the Advanced APM bonus that Congress created in MACRA for an additional six years and gives the HHS secretary greater discretion to determine thresholds providers must reach to receive those bonuses. These bonuses have been instrumental in encouraging participation inrisk-based APMs but expire at the end of this year. Congress must act to prolong these bonuses and encourage more providers to enter into APMs to extend the benefits we describe above to more Medicare beneficiaries.

Unfortunately, the pace of APM adoption has not been as fast as Congress desired when MACRA was passed in 2015. Today, there are more than 30 million traditional Medicare patients still in unmanaged, uncoordinated care. Last week, CMS released data showing a very modest year-over-year growth in ACO participation, continuing a troubling trend of flat participation in MSSP. Greater incentives are needed for providers to participate in APMs, to outweigh the risk, uncertainty, and sizeable upfront and ongoing investments needed to participate. Congress can play a strong role in rebalancing those incentives and encouraging growth in Medicare programs that promote better patient outcomes at lower cost.

We appreciate the opportunity to express our views on the Fiscal Responsibility and Economic Growth Subcommittee, U.S. Senate Finance Committee hearing regarding the Hospital Insurance Trust Fund and the Future of Medicare Financing. We support the efforts of the Subcommittee to ensure that the Medicare program remains solvent and look forward to working with the Committee on this important topic.

American Medical Association	AMGA
America's Physician Groups	Association of American Medical Colleges
Health Care Transformation Task Force	Medical Group Management Association
National Association of ACOs	Premier Healthcare Alliance

CENTER FOR FISCAL EQUITY
14448 Parkvale Road, #6
Rockville, Maryland 20853
fiscalecquitycenter@yahoo.com

Statement of Michael G. Bindner

Chairman Warren and Ranking Member Cassidy, thank you for the opportunity to submit these comments for the record to the Committee on Finance on Medicare reform.

The Hospital Trust Fund (Medicare Part A), even though it has no cap, is funded by a payroll tax that leaves non-wage income on the table. Wages have mostly declined, while the top 4% of filers (who take home 33% of Adjusted Gross Income) receive only half of their income from wages. The other half is not touched (and is a product of the labor of the lower 96%).

It is no wonder that the fund is endemically close to falling below revenue. Raising the HI payroll tax to 5% would balance the fund forever—but it leaves too much of AGI on the table.

---

[11] *https://www.congress.gov/bill/117th-congress/house-bill/4587?q=%7B%22search%22%3A%5B%22Value+in+Health+Care+Act%22%2C%22Value%22%2C%22in%22%2C%22Health%22%2C%22Care%22%2C%22Act%22%5D%7D&s=1&r=1.*

Among the elderly and severely disabled, there is a constant battle between nursing homes and hospitals for cost avoidance, with patients in the middle.

There is certainly much more to be said, and I count on the listed witnesses to say it. I am sure that some of them have interesting proposals for reform. I have my own, which I will now detail.

HI cannot be treated as one component without affecting all other components. This is especially the case as some form of single payer system is inevitable. Whether you call the public option Expanded Medicaid or the real thing, the entire system is in need of change. More detailed analysis of single-payer options can be found in Attachment One.

Universal coverage, starting with a public option under the Affordable Care Act, with eventual evolution to some type of single-payer system seems like our best path. A public option will only pass if pre-existing condition reforms are abolished with public option enrollment being automatic upon rejection.

The public option must be subsidized, replacing Medicaid for the disabled and those not requiring long-term nursing care. Long-term care should be removed from states and replaced with a new federal Medicare Part E.

The profit motive, with the need to constantly increase profits to attract Wall Street investment or keep stock prices growing will lead to an ever increasing number of people who will be considered uninsurable, thus relying on the public option.

Most healthcare systems will provide services to both comprehensive insurance beneficiaries, the retired, the disabled and those with the public option. In other words, Medicare for All is our future, with the only exception being firms abandoning the system and providing their own doctors while making arrangements with local hospitals and specialists—essentially creating local HMOs.

The major issue here is funding, although more efficiency will reduce prices. Costs are already minimized by the for profit and by governmental medical care (which often uses for profit networks). To repeat, with a shout, *the issue is price, not cost!*

The problem with the Affordable Care Act is that much of its funding came from taxes on capital gains and income falling on the top third of taxpayers. In other words, the upper and upper-middle classes. IRS data shows that about half of Adjusted Gross Income for these classes is from non-wage income. Membership in these classes is limited to the top 4% of taxpayers.

This is politically unacceptable, as the multiple attempts to repeal the ACA have shown. Broad based taxes are necessary and should be bipartisan. Any political promise to the contrary must be broken. No votes will be lost to either party by doing so. Few members of the middle or working classes will shift their allegiance to the other party because of tax policy changes.

Members of the current majority party will simply not give up on their political home because their taxes go up. One of the key reasons for party identification among frequent voters is economic policy—not the details but a belief in who should be taxed. Progressives will never join the Republican Party for a campaign promise not kept.

The stupidest myth in American history is the belief that anyone held George H.W. Bush to account for breaking his "no new taxes" pledge. They did not vote for Perot because of it—his voters were sending a message to the entire system and drew from both parties. If anyone believes that any Bush voter shifted to Bill Clinton for violating the NNT pledge, I have a collection of bridges over the Potomac you may be interested in purchasing.

Payroll taxes are regressive, so they should not be used to fund the public option, et al. Indeed, all Medicare taxation should be shifted to a less regressive consumption tax. This tax is less regressive because it takes from profit and wages in equal measure. Taxing only wages or only capital leads to either too much progressivity or too little.

The only question is how to collect these taxes. If it is more important to give exporters (and overseas customers) an economic break, the standard border adjustable goods and services tax is best.

To preserve the private option—either for comprehensive insurance or employer-provided care—a subtraction (aka net business receipts) value-added tax is best. Such a tax should also include distribution of (more generous) child tax credits.

Paying these taxes through employers, rather than the Internal Revenue Service, corrects the economic failure that simply relying on privately negotiated wages creates while taking away the "stink of welfare" found in the American Recovery Plan Act's distribution mechanism.

The provisions in the Affordable Care Act creating surtaxes to fund healthcare must be repealed, as should both dividend, interest and capital gains taxation (as well as rent) currently collected through personal income taxes. Instead, tax transactions, rather than people at the same rate now paid for the highest rate for long-term capital gains. The current rate (including ACA taxes) is just short of 23.8%. The proposed rate is 28.8% (adding proposed surtaxes for high incomes).

Much money is spent on campaign contributions to continue going back and forth between these rates. I have little hope for compromise—although splitting the difference between 26% and 27% seems reasonable.

What would such a tax pay for, if not healthcare? Fund the military—especially overseas deployments which serve our security and economic interests abroad, repayment of the Social Security Trust Fund and begin funding Net Interest rather than rolling it over into new debt. The international economic system can only favor the Dollar and U.S. Debt for so long. Every empire falls. The question is, who will lose the most if American debt becomes worthless?

Please see the second attachment for more detail on our proposed tax reform plan.

Using data from the Federal Reserve Survey of Consumer Finance, the top 10% of households indirectly hold 56% of debt held in Federal Reserve and Bank Assets and Long Term Investments and 77% of mutual fund and direct debt holdings. According to the Pareto Rule, half of each of these fund pools is owned by the top 1% of households. They have the most to lose if the debt crashes. Use an Asset Value Added Tax (on transactions) to decrease what is becoming an unworkable level of debt.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment One—Single-Payer, June 12, 2019

There is no logic in rewarding people with good genes and punishing those who were not so lucky (which, I suspect, is most of us). Nor is there logic in giving health insurance companies a subsidy in finding the healthy and denying coverage for the sick, except the logic of the bottom line. Another term for this is piracy. Insurance companies, on their own, resist community rating and voters resist mandates—especially the young and the lucky. As recent reforms are inadequate (aside from the fact of higher deductibles and the exclusion of undocumented workers), some form of single-payer is inevitable. There are three methods to get to single-payer.

The first is to set up a **public option** and end protections for pre-existing conditions and mandates. The public option would then cover all families who are rejected for either pre-existing conditions or the inability to pay. In essence, this is an expansion of Medicaid to everyone with a pre-existing condition. As such, it would be funded through increased taxation, which will be addressed below. A variation is the expansion of the Uniformed Public Health Service to treat such individuals and their families.

The public option is inherently unstable over the long term. The profit motive will ultimately make the exclusion pool grow until private insurance would no longer be justified, leading again to single-payer if the race to cut customers leads to no one left in private insurance who is actually sick. This eventually becomes Medicare for All, but with easier passage and sudden adoption as private health plans are either banned or become bankrupt. Single-payer would then be what occurs.

The second option is Medicare for All, which I described in an attachment to yesterday's testimony and previously in hearings held May 8, 2019 (Finance) and May 8, 2018 (Ways and Means). Medicare for All is essentially Medicaid for All without the smell of welfare and with providers reimbursed at Medicare levels, with the difference funded by tax revenue.

Medicare for All is a really good slogan, at least to mobilize the base. One would think it would attract the support of even the Tea Partiers who held up signs saying "Don't let the government touch my Medicare!" Alas, it has not. This has been a conversation on the left and it has not gotten beyond shouting slogans either. We need to decide what we want and whether it really is Medicare for All. If we want

to go to any doctor we wish, pay nothing and have no premiums, then that is not Medicare.

There are essentially two Medicares, a high option and a low one. One option has Part A at no cost (funded by the Hospital Insurance Payroll Tax and part of Obamacare's high unearned income tax as well as the general fund), Medicare Part B, with a 20% copay and a $135 per month premium and Medicare Part D, which has both premiums and copays and is run through private providers. Parts A and B also are contracted out to insurance companies for case management. Much of this is now managed care, as is Medicare Advantage (Part C).

Obamacare has premiums with income-based supports and copays. It may have a high option, like the Federal Employee Health Benefits Program (which also covers Congress) on which it is modeled, a standard option that puts you into an HMO. The HMO drug copays for Obamacare are higher than for Medicare Part C, but the office visit prices are exactly the same.

What does it mean, then, to want Medicare for All? If it means we want everyone who can afford it to get Medicare Advantage Coverage, we already have that. It is Obamacare. The reality is that Senator Sanders wants to reduce Medicare copays and premiums to Medicaid levels and then slowly reduce eligibility levels until everyone is covered. Of course, this will still likely give us HMO coverage for everyone except the very rich, unless he adds a high-option PPO or reimbursable plan.

Either Medicare for All or a real single-payer would require a very large payroll tax (and would eliminate the HI tax) or an employer paid subtraction value-added tax (so it would not appear on receipts nor would it be zero rated at the border, since there would be no evading it), which we discuss below, because the Health Care Reform debate is ultimately a tax reform debate. Too much money is at stake for it to be otherwise, although we may do just as well to call Obamacare Medicare for All.

The third option is an **exclusion for employers,** especially employee-owned and cooperative firms, who provide medical care directly to their employees without third party insurance, with the employer making HMO-like arrangements with local hospitals and medical practices for inpatient and specialist care.

Employer-based taxes, such as a subtraction VAT or payroll tax, will provide an incentive to avoid these taxes by providing such care. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid or Medicare for All. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral—as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. The employee-ownership must ultimately expand to most of the economy as an alternative to capitalism, which is also unstable as income concentration becomes obvious to all.

The key to any single-payer option is securing a funding stream. While payroll taxes are the standard suggestion, there are problems with progressivity if such taxes are capped and because profit remains untaxed, which requires the difference be subsidized through higher income taxes. For this reason, funding should come through some form of value-added tax.

Timelines are also concerns. Medicare for All is be done gradually by expanding the pool of beneficiaries, regardless of condition. Relying on a Public Option will first serve the poorest and the sickest, but with the expectation that private insurance will enlarge the pool of those not covered until the remainder can safely be incorporated into a single-payer system through legislation or bankruptcy.

Attachment Two—Tax Reform, Center for Fiscal Equity, December 7, 2021

Individual payroll taxes. Employee payroll tax of 7.2% for Old-Age and Survivors Insurance. Funds now collected as a matching premium to a consumption-tax-based contribution credited at an equal dollar rate for all workers qualified within a quarter. An employer-paid subtraction value-added tax would be used if offsets to private accounts are included. Without such accounts, the invoice value-added tax would collect these funds. No payroll tax would be collected from employees if all contributions are credited on an equal dollar basis. If employee taxes are retained, the ceiling would be lowered to $100,000 to reduce benefits paid to wealthier individuals

and a $16,000 floor should be established so that Earned Income Tax Credits are no longer needed. Subsidies for single workers should be abandoned in favor of radically higher minimum wages. If a $10 minimum wage is passed, the employee contribution floor would increase to $20,000.

Wage Surtaxes. Individual income taxes on salaries, which exclude business taxes, above an individual standard deduction of $100,000 per year, will range from 7.2% to 57.6%. This tax will fund net interest on the debt (which will no longer be rolled over into new borrowing), redemption of the Social Security Trust Fund, strategic, sea and non-continental U.S. military deployments, veterans' health benefits as the result of battlefield injuries, including mental health and addiction and eventual debt reduction.

Our proposed brackets have been increased from $85,000 to $100,000 because this is the income level at the top of the 80% of tax paying households who earn the bottom third of adjusted gross income. Earners above this level are considered middle class. Likewise, the top 1% of income earners are at the $500,000 level, which will be used as the start of the highest rate.

Asset Value-Added Tax (A–VAT). A replacement for capital gains taxes, dividend taxes, and the estate tax. It will apply to asset sales, dividend distributions, exercised options, rental income, inherited and gifted assets and the profits from short sales. Tax payments for option exercises, IPOs, inherited, gifted and donated assets will be marked to market, with prior tax payments for that asset eliminated so that the seller gets no benefit from them. In this perspective, it is the owner's increase in value that is taxed. As with any sale of liquid or real assets, sales to a qualified broad-based Employee Stock Ownership Plan will be tax free. These taxes will fund the same spending items as income or S–VAT surtaxes.

This tax will end Tax Gap issues owed by high income individuals. A 26% rate is between the GOP 23.8% rate (including ACA–SM surtax) and the Democratic 28.8% rate as proposed in the Build Back Better Act. It's time to quit playing football with tax rates to attract side bets. A single rate also stops gaming forms of ownership. Lower rates are not as regressive as they seem. Only the wealthy have capital gains in any significant amount. The de facto rate for everyone else is zero. For now, however, a 28.8% rate is assumed if reform is enacted by a Democratic majority in both Houses.

Subtraction Value-Added Tax (S–VAT). These are employer paid Net Business Receipts Taxes. S–VAT is a vehicle for tax benefits, including

- Health insurance or direct care, including veterans' health care for non-battlefield injuries and long-term care.
- Employer paid educational costs in lieu of taxes are provided as either employee-directed contributions to the public or private unionized school of their choice or direct tuition payments for employee children or for workers (including ESL and remedial skills). Wages will be paid to students to meet opportunity costs.
- Most importantly, a refundable child tax credit at median income levels (with inflation adjustments) distributed with pay.

Subsistence level benefits force the poor into servile labor. Wages and benefits must be high enough to provide justice and human dignity. This allows the ending of state administered subsidy programs and discourages abortions, and as such enactment must be scored as a must pass in voting rankings by pro-life organizations (and feminist organizations as well). To assure child subsidies are distributed, S–VAT will not be border adjustable.

The S–VAT is also used for personal accounts in Social Security, provided that these accounts are insured through an insurance fund for all such accounts, that accounts go toward employee-ownership rather than for a subsidy for the investment industry. Both employers and employees must consent to a shift to these accounts, which will occur if corporate democracy in existing ESOPs is given a thorough test. So far it has not. S–VAT funded retirement accounts will be equal-dollar credited for every worker. They also have the advantage of drawing on both payroll and profit, making it less regressive.

A multi-tier S–VAT could replace income surtaxes in the same range. Some will use corporations to avoid these taxes, but that corporation would then pay all invoice and subtraction VAT payments (which would distribute tax benefits). Distributions from such corporations will be considered salary, not dividends.

Invoice Value-Added Tax (I–VAT). Border adjustable taxes will appear on purchase invoices. The rate varies according to what is being financed. If Medicare for All does not contain offsets for employers who fund their own medical personnel or for personal retirement accounts, both of which would otherwise be funded by an S–VAT, then they would be funded by the I–VAT to take advantage of border adjustability. I–VAT also forces everyone, from the working poor to the beneficiaries of inherited wealth, to pay taxes and share in the cost of government. Enactment of both the A–VAT and I–VAT ends the need for capital gains and inheritance taxes (apart from any initial payout). This tax would take care of the low-income Tax Gap.

I–VAT will fund domestic discretionary spending, equal dollar employer OASI contributions, and non-nuclear, non-deployed military spending, possibly on a regional basis. Regional I–VAT would both require a constitutional amendment to change the requirement that all excises be national and to discourage unnecessary spending, especially when allocated for electoral reasons rather than program needs. The latter could also be funded by the asset VAT (decreasing the rate by from 19.5% to 13%).

As part of enactment, gross wages will be reduced to take into account the shift to S–VAT and I–VAT, however net income will be increased by the same percentage as the I–VAT. Adoption of S–VAT and I–VAT will replace pass-through and proprietary business and corporate income taxes.

Carbon-Added Tax (C–AT). A Carbon tax with receipt visibility, which allows comparison shopping based on carbon content, even if it means a more expensive item with lower carbon is purchased. C–AT would also replace fuel taxes. It will fund transportation costs, including mass transit, and research into alternative fuels (including fusion). This tax would not be border adjustable unless it is in other nations, however in this case the imposition of this tax at the border will be noted, with the U.S. tax applied to the overseas base.

Tax Reform Summary

This plan can be summarized as a list of specific actions:

1. Increase the standard deduction to workers making salaried income of $350,00 and over, shifting business filing to a separate tax on employers and eliminating all credits and deductions—starting at 7.2%, going up to 28.8%, in $50,000 brackets.
2. Shift special rate taxes on capital income and gains from the income tax to an asset VAT. Expand the exclusion for sales to an ESOP to cooperatives and include sales of common and preferred stock. Mark option exercise and the first sale after inheritance, gift or donation to market.
3. Employers distribute the child tax credit with wages as an offset to their quarterly tax filing (ending annual filings).
4. Employers collect and pay lower tier income taxes, starting at $100,000 at 7.2%, with an increase to 14.4% for all salary payments over $150,000 going up 7.2% for every $50,000- up to $250,000.
5. Shift payment of HI, DI, SM (ACA) payroll taxes to employers, remove caps on employer payroll taxes and credit them to workers on an equal dollar basis.
6. Employer paid taxes could as easily be called a subtraction VAT, abolishing corporate income taxes. These should not be zero rated at the border.
7. Expand current state/federal intergovernmental subtraction VAT to a full GST with limited exclusions (food would be taxed) and add a federal portion, which would also be collected by the states. Make these taxes zero rated at the border. Rate should be 19.5% and replace employer OASI contributions. Credit workers on an equal dollar basis.
8. Change employee OASI of 7.2% from $18,000 ($20,000 for $10 minimum wage) to $100,000 income are optional taxes for Old Age and Survivors Insurance.

CENTER FOR MEDICARE ADVOCACY
1025 Connecticut Avenue, NW #709
Washington, DC
(202) 293–5760
https://medicareadvocacy.org/

The Center for Medicare Advocacy (Center) is pleased to provide a statement for the record for the above-referenced hearing. The Center, founded in 1986, is a national,

non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality health care. At the Center, we educate older people and people with disabilities to help secure fair access to necessary health care services. We draw upon our direct experience with thousands of individuals to educate policy makers about how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that people receive the health care benefits to which they are legally entitled, and to the quality health care they need.

Overview

The annual release of the Medicare Trustees report, which projects the fiscal health of the Medicare program, focusing on the Part A Trust Fund, often serves as an impetus for calling for Medicare changes and cuts. The latest report, released in August 2021, projects that the Part A Trust Fund will be depleted by 2026—unchanged from the previous projection, despite the impact of the COVID–19 pandemic.

The solvency of the Trust Fund is often misunderstood and misconstrued. Even if the Trust Fund were to be depleted as projected, the program would still be able to pay out approximately 90% of Medicare Part A benefits. While not ideal, this is far from "bankruptcy", which is often alleged by those seeking to cut Medicare spending. Further, the date of projected insolvency is an estimate, and could easily change again—as it has many times before.

The Trust Fund largely reflects the health of the economy. At various times since 1970, the trustees have projected Trust Fund insolvency in as few as four years or as many as 28 years. While the Part A Trust Fund is mostly funded by payroll taxes, Medicare Part B, which would cover these expanded benefits, is funded by a certain percent of general revenues and premiums, and therefore cannot "go broke."

Recent discussions in Congress surrounding the Build Back Better Act have created a rare opportunity to make meaningful improvements to Medicare and other critical programs. Yet the associated costs and concerns about the Medicare Trust Fund are often raised as barriers to doing so. Despite many misconceptions, the proposed dental, hearing, and vision benefits would have been covered under Medicare Part B, not through Part A and the Trust Fund. Further, as the Center and others have asserted, it is highly likely that spending to expand Medicare coverage to include dental, hearing and vision coverage would actually yield savings to the Medicare program in other areas.[1]

Medicare's fiscal solvency can be strengthened through various means. Below, we provide an excerpt from a May 2021 issue brief written by Center for Medicare Advocacy Visiting Scholar Marilyn Moon which outlines potential Medicare funding solutions. We also focus, below, on one option for reducing programmatic spending—addressing ongoing Medicare Advantage overpayments.

Center for Medicare Advocacy Report: "Ensuring Medicare's Financial Health"

In a May 2021, the Center released an issue brief titled "Medicare and Revenue—Looking Back, Looking Forward"[2] by Center Visiting Scholar Marilyn Moon. In this report, we examined how Medicare has operated over time, how well it is doing at present, and what changes have been used in the past to keep the program financially strong. Below is an excerpt of this report focusing on both short-term and longer-term solutions to Medicare funding (omitting citations):

> **Short-term solutions.** In the near term, funding decisions need to recognize the short-term economic problems from the pandemic and not expect to bolster the Part A trust fund through the usual approaches. General tax increases do not make sense as the economy is recovering. But there could be proposals to help pay for some of these pandemic costs (for people of all ages) through new and temporary revenue sources. Looking for ways to level the unequal burdens that this health and financial crisis has imposed may include special surcharges

[1] *See, e.g.,* CMA Alert, "Medicare Is at a Crossroads—Time to Dispel Myths Hindering an Historic Expansion of Benefits" (September 2, 2021), available at: *https://medicareadvocacy.org/stop-the-myths-about-expanding-medicare-benefits/*.

[2] Center for Medicare Advocacy, "Medicare and Revenue—Looking Back, Looking Forward," by Center Visiting Scholar Marilyn Moon (May 2021), available at: *https://medicareadvocacy.org/medicare-and-revenue-looking-back-looking-forward/*. *Also see, e.g.,* CMA Alert, "Commonwealth Fund Issues Series of Articles Addressing Medicare's Fiscal Solvency—Introductory Statement by Marilyn Moon" (February 11, 2021), available at: *https://medicareadvocacy.org/m-moon-medicare-solvency/*.

on incomes—especially seeking to tax those who have profited during this period. This might not only mean taxes on higher income people in general, but also a temporary surtax on "excess" profits made by those who were fortunate enough to work in areas that thrived during this period. While many businesses and workers experienced difficulties in functioning while health concerns required stringent limitations on activities, others were in a position to benefit. Such an excess profits surcharge might compare incomes before and during the pandemic to determine whether there are feasible ways to reduce some of the inequality attributable to the enormous disruptions this disease imposed on the way that the economy functions. These revenues could help bolster Medicare's higher costs.

Some other more minor changes in tax laws could also be considered. Key among these would be to dedicate at least a portion of the existing Net Investment Income Tax which was passed as part of the Affordable Care Act to the Part A Trust Fund. Although it was justified in the legislation as a way to help finance Medicare, *none* of that revenue was dedicated to the Part A Trust Fund. This tax on those with higher incomes is expected to bring in approximately $350 billion to the U.S. Treasury over the next 10 years and at least some of it could be earmarked for Part A. (Closing other tax loopholes might also be an option and are discussed below.)

Solutions over the longer term. To ensure stable financing for Medicare over time, it is important to look at the two largest sources of revenues that support the federal government: payroll taxes and personal income taxes. As noted above, both are important current sources of financing for Medicare and over time, general revenues have grown and will continue to grow as a share of the total even if no policy changes are made. Each has advantages and disadvantages.

Payroll taxes have always been popular among the general public, likely because they are simple, administered by employers with no filing requirements by most workers, and because they are dedicated to Social Security and Medicare which remain popular programs. Taxpayers see a direct link between their taxes and these key sources of retirement and disability protections. Traditionally, the payroll tax has been criticized by economists, largely because of its lack of progressivity. Assessed only against wages—and for a long time with an upper limit on the wages subject to tax—the burdens of the tax fall more heavily on persons with lower incomes. On the one hand, progressivity for the Medicare portion of the payroll tax improved when the taxable wage cap was eliminated and when additional requirements for higher income taxpayers and beneficiaries to pay more were added to the program. But, wages have also declined as a share of incomes for Americans over the years, with income from interest and dividends rising particularly for those with higher incomes. This worsens the progressivity of the tax to some degree.

Nonetheless, a modest increase in the payroll tax could raise substantial new revenues to Medicare's Part A Trust Fund, extending its life substantially and keeping the dedicated nature of the tax that funds most of Part A. For example, a Congressional Budget Office estimate in 2020 indicated that a one percentage point increase (0.5 percent each on employers and employees) would raise nearly $900 billion between 2021 and 2030. Introducing such a change through a more gradual increase in that rate over time as the economy recovered would bring in less, but still provide substantial support for the Part A Trust Fund. And since general revenues by law will naturally increase over time to fund Parts B and D, this approach would mean that both types of taxes will expand to fund Medicare over time.

An alternative would be to add personal income taxes to the funding for Part A (presumably as a dedicated amount to retain the Trust Fund nature of this part of the program). Income taxes are applied to all types of income, including wages, capital gains, and interest and dividends. This would mean that there would be no extra burden on individuals whose incomes come mainly from wages, but that the burden would be more evenly spread across all income sources. This breaks the historical link between wages and retirement benefits, but that has changed to a considerable degree over time anyway.

Another variation of this approach would be to specifically target certain types of income to be devoted to the Part A Trust Fund. Closing various tax loopholes (for both personal and corporate income taxes) and increasing IRS enforcement capabilities are often popular proposals and have been advocated for a variety

of purposes. The Congressional Budget Office has offered a number of options for increasing revenue in this way, often with a particular focus on capital gains treatment in the personal income tax. For example, a tax on capital gains could be used to explicitly supplement the existing payroll tax and hence implicitly enhance the progressivity of taxation. This would avoid raising taxes further on wages and instead tax income from capital—often associated with those with higher incomes. But it would also fall disproportionately on older taxpayers who are more likely to own stocks and bonds than younger persons with similar incomes. That could be viewed as a positive by those who would like to see seniors pay a greater share of the costs of Medicare, but it would further add to the shifting of the burden of costs onto this group as was noted above. Another loophole closer might be to eliminate existing exclusions from tax offered to various business structures. For example, including income from S Corporations and limited partnerships in various tax bases such as the Net Investment Income Tax has been proposed. Although it would affect only a very small number of people, such a change could raise over $200 billion over a ten year period.

Medicare Savings Could be Achieved by Correcting the Imbalance in Medicare Advantage Payment

Overpayments to Medicare Advantage (MA) plans continue to negatively impact Medicare's finances. The Medicare Payment Advisory Commission (MedPAC) noted in their March 2021 report to Congress [3] that Medicare payments to MA plans average 104% of spending in traditional Medicare. MedPAC stated in a press release announcing the report that Medicare paid MA plans an estimated $317 billion in 2020 (not including payments to cover Part D expenses):

> This level of payment reflects **Medicare payments that were higher for MA enrollees than the program would have spent for similar beneficiaries in traditional FFS Medicare, continuing a long-standing trend.** Using plan bid data for 2021, we estimate that MA payments will be 101 percent of FFS spending. However, for several years, the Commission has expressed concern that enrollees in MA plans have higher risk scores than similar beneficiaries in FFS because of plans' more intensive coding practices that result in excess payments to plans. Accounting for coding intensity, in 2021, we estimate that **Medicare payments to MA plans actually average 104 percent of FFS spending** (quality bonuses in MA account for an estimated 2 to 3 percentage points of MA payments in 2021). Medicare payments to MA plans continue to exceed FFS spending levels, despite the fact that plan bids in 2021 decreased to 87 percent of FFS, in aggregate—a record low.
>
> In prior work, we identified some MA policies that need immediate improvement. The Commission previously recommended in 2017 that CMS reduce excess payments stemming from plans' coding practices, which **would improve equity across plans and produce savings for Medicare.** In 2020, the Commission also recommended replacing the MA quality bonus program with a value incentive program that would more accurately characterize the quality of care in MA. Currently, the Commission is assessing an alternative MA benchmark policy that would improve equity and efficiency in the MA program [emphasis added].

Echoing MedPAC's findings, in August 2021 the Kaiser Family Foundation (KFF) released a report [4] outlining how Medicare spending is higher and growing faster per person for beneficiaries in MA than in traditional Medicare. Despite most plans submitting bids below the local benchmarks, KFF notes that the MA program "has never generated savings relative to traditional Medicare" and while higher payments have led to coverage of some limited extra benefits for plan enrollees, "the higher payments have also led to higher Medicare spending than would have occurred under traditional Medicare and higher Medicare Part B premiums paid by all beneficiaries, including those in traditional Medicare."

The KKF report concludes, in part:

---

[3] MedPAC, March 2021 "Report to the Congress: Medicare Payment Policy," available at: *https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/*.

[4] Kaiser Family Foundation, "Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges" (August 2021), available at: *https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/*.

> As more Medicare beneficiaries enroll in private plans, differences in Medicare payments across Medicare Advantage and traditional Medicare will lead to even higher Medicare spending, and more generous benefits for beneficiaries in Medicare Advantage than traditional Medicare. That higher spending increases Part B premiums paid by all Medicare beneficiaries, including those who are not in a Medicare Advantage plan, and contribute to the financing challenges facing the Medicare [Part A] Trust Fund. Further, these projections raise questions of equity between Medicare Advantage and traditional Medicare because the faster growth in spending per Medicare Advantage enrollee, compared to traditional Medicare beneficiaries, is in part due to rising rebates to private plans, which cover the cost of benefits not available to traditional Medicare beneficiaries. Although taking steps to address the fiscal challenges facing Medicare are not front and center in current Medicare policy discussions, policymakers may soon be on the lookout for options to achieve Medicare savings to fund other spending priorities or extend the solvency of the Medicare [Part A] Trust Fund. This analysis suggests that reducing the difference in payments between Medicare Advantage and traditional Medicare would generate savings, with the potential for reductions in extra benefits for Medicare Advantage enrollees.

In other words, all Medicare beneficiaries are subsidizing the limited dental, hearing, vision and other benefits only available through MA plans, to the minority of beneficiaries who choose MA, or for whom MA plans are the sole retiree option. The Center asserts that it is time we spread this funding around in a more equitable way, to benefit all Medicare beneficiaries—both those in private plans and those in traditional Medicare. To continue with the status quo would be "unnecessary and unfair" to the Medicare program as a whole.[5]

Conclusion

It is clear that policymakers must confront long-term fiscal challenges facing the Medicare program. While various health policy experts have raised MA overpayments as a potential source of addressing the program's fiscal solvency, wasteful spending on private MA plans is often overlooked by policymakers—particularly those issuing the loudest warnings of the program's impending fiscal doom.

We appreciate the opportunity to submit this statement for the record. For additional information, please contact David Lipschutz, Senior Policy Attorney, DLipschutz@MedicareAdvocacy.org at 202–293–5760.

STATEMENT SUBMITTED BY CLIVE FIELDS, M.D.

Chairwoman Warren, Ranking Member Cassidy, and distinguished members of the Subcommittee, thank you for the opportunity to submit this statement about the future of Medicare and approaches to strengthen the Hospital Insurance Trust Fund while providing better healthcare to Medicare beneficiaries.

I am the Chief Medical Officer and a co-founder of VillageMD, which currently serves 1.6 million patients at 250 Village Medical clinics in 19 U.S. markets. Our company has a bold founding principle: changing primary care in the United States so that our country can be the global leader in health outcomes regardless of background and income. We're investing in primary care to keep people healthy and prevent chronic conditions from occurring, and to lower costs across the board.

Healthcare experts have argued for years that we should move away from the dysfunctional, unsustainable[1] fee-for-service Medicare reimbursement system and toward value-based models that incentivize better health outcomes such as reduced hospitalizations and post-acute care costs.

The Direct Contracting model program is one of the federal Center for Medicare and Medicaid Innovation's most promising value-based programs. VillageMD is proud to be one of the leading Direct Contracting Entities (DCEs) in the model program. Our doctors appreciate that it puts primary-care providers at the center of care teams and rewards physicians who build ongoing relationships with patients. By providing payments for each person in a provider's care based on their disease burden, the

---

[5] *See, e.g.,* CMA Alert, "Policy-Makers Should Review Overpayments to Medicare Advantage when Considering Medicare Fiscal Solvency" (March 18, 2021), available at: *https://medicareadvocacy.org/policy-makers-should-review-overpayments-to-medicare-advantage-when-considering-medicare-fiscal-solvency/*.

[1] *https://www.commonwealthfund.org/blog/2021/putting-medicare-solvency-projections-perspective.*

program incentivizes patients' overall health, rather than providing medical services piecemeal. Patients retain freedom of choice to see any Medicare provider.

By not focusing on volume, primary-care providers can spend the time needed to provide high-quality care, especially for patients with chronic conditions who require comprehensive care plans. In the U.S., nearly $4 trillion per year[2] is spent on healthcare, and more than 85%[3] of this amount is tied to patients with chronic disease. Keeping those people healthier longer is a potential source of tremendous savings for the healthcare system and can allow people to live more fulfilling lives. Coordination of care across multiple settings facilitates a long-term partnership with the patient, prerequisites for improved management of chronic conditions.

Primary-care practices are receiving increased investment due to the Direct Contracting model, which is encouraging providers to build clinics and create access in underserved rural and urban communities. VillageMD has committed to launch Village Medical at Walgreen's primary-care practices in more than 500 medically underserved areas, which will serve millions of Americans on Medicaid and Medicare in care deserts.

The Direct Contracting model draws upon private-sector approaches to risk-sharing arrangements and payment and reduces administrative burden. Risk adjustment means the provider is paid more if the patient is sicker because it will take more time, effort and cost to treat the patient. One of the benefits of risk adjustment is that it centers attention on the diagnosis of the patient instead of creating meaningless tasks and measurements to determine payment that do not add value for the patient.

VillageMD has demonstrated that primary care-centric management can lead to considerable cost reduction with over $61M in gross savings generated from 2018-2020 in its longest standing and largest ACO. With Village Medical patients able to book a same day appointment and over 15% of available appointments after hours or on weekends, VillageMD has shown that proactive and accessible primary care generates cost savings by reducing admissions (close to 5% year over year) and skilled nursing visits (over 9%) for ACO participants, all while generating improved quality of care. In fact, four preventative measures saw greater than a 40% improvement from 2018 to 2020. Colon cancer screenings increased by almost three-fold, which means thousands of additional Medicare Beneficiaries received preventative colon cancer screenings.

Critics of Direct Contracting suggest that DCEs will engage in aggressive diagnostic "upcoding" and mis-categorize patients to qualify for higher risk-adjusted payments. Actually, DCEs are subject to multiple coding limitations[4] and Direct Contracting risk adjustment is not undermined by the complicated regulations and litigation[5] that limit government action on mis-coding in Medicare Advantage. The opportunity to improve risk adjustment oversight and educate providers on effective coding practices is a reason to keep the Direct Contracting program, not end it prematurely.

DCEs are ineligible for shared savings without achieving CMS's quality benchmarks.[6] Relative to prior existing initiatives, the Direct Contracting payment models include a stronger set of quality measures that focus more on outcomes and beneficiary experience than on process.

There are going to be starts and stops on the path to a Medicare system that better serves patients, but value-based care is ultimately the key to improved health outcomes and lower costs to the system. By creating networks of providers, integrating their referrals, and assessing patient utilization and outcomes, value-based programs like Direct Contracting present the best existing opportunity to reform volume-based fee-for-service Medicare and, in so doing, extend Medicare's solvency.

In the long term, the key to success in value-based models like Direct Contracting is providing quality care that is personalized, preventive, comprehensive and equitable. This is the first year of a planned six-year model program. During that time,

---

[2] *https://jamanetwork.com/journals/jama/article-abstract/2752664?guestAccessKey=bf8f9802-be69-4224-a67f-42bf2c53e027&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=100719.*

[3] *https://www.cdc.gov/chronicdisease/about/costs/index.htm.*

[4] *https://innovation.cms.gov/media/document/gpdc-py2022-risk-adj.*

[5] *https://www.govinfo.gov/content/pkg/USCOURTS-caDC-18-05326/pdf/USCOURTS-caDC-18-05326-0.pdf.*

[6] *https://innovation.cms.gov/media/document/gpdc-py2022-qual-meas-meth.*

CMS will determine whether it delivers high-value care to patients and savings for the Medicare system. That evaluation should be based on data, not politics.

FOOTHILLS COALITION FOR UNIVERSAL HEALTHCARE

I would like to offer this committee my feedback on the hearing chaired by Senator Warren that just completed being broadcast today February 2nd. I would also appreciate a link to the replay so that I can share this hearing with others.

Everything the witnesses had to say was right on the mark. Most importantly Dr. Susan Rogers, MD, FACP

President Physicians for a National Health Program from Chicago, IL. She was 100% right that our traditional Medicare system is being sold out to profiteering entities to the detriment of the trust funds solvency.

The government must put a stop to the MA and DCE spread before it's too late and the system is totally bankrupt and many seniors will have died in the process as a result of a lack for quality healthcare, denials of coverage and resulting medical bankruptcies.

We must not allow this to continue. Our government is supposed to be working for the citizens of this country NOT for the profits of the drug industry and the corporate profit making entities attempting to take over behind the scenes. If our government truly cares and I mean truly cares about the patients and not the profiteers they will solve these issues now and not let them continue to make our healthcare system worse than it already is. We cannot afford to allow this to continue another day.

It's time for a National Healthcare Program that truly provides quality care to the patient and not profits to the industries controlling it.

Respectfully submitted.

Terry Brady
Chair
https://www.facebook.com/profile.php?id=100072402669140
360–588–6103 or 916–740–9519

LETTER SUBMITTED BY ROB HOFFMAN

U.S. Senate
Committee on Finance
Subcommittee on Fiscal Responsibility and Economic Growth

A 25 year acupuncture practitioner doing the best I can to help the working class of this country heal.

Stop Self-serving Hospital and Insurance company executives who continue stealing from the working class of this country.

They've done plenty of damage already.

Kindly,

Rob Hoffman

LETTER SUBMITTED BY PAT KANZLER, R.N.

Hi.

I am 69, on Medicare, and I rejoiced when I found I was on it, because I no longer had to fight over network problems, and my provider and I would decide my best course, *not a nonmedical* middle man/woman.

How dare you allow Wall Street or financial hawks to privatize Medicare?

I am an R.N., and I see up close and personal what happens, health care goes down, profits go up, and that is *not* what health care is all about, it is about *wellness,* it is about *humanity not consumers,* it is about *citizens!*

I watch the elderly die or go bankrupt. I watch a revolving door of people who leave well, but come back in the hospital ill because they cannot afford medication or treatments. I watch people lose faith in science and medicine because they no longer can afford to see a health-care provider and believe all sorts of conspiracy theories, and the taking over of Medicare by making it a *business* will not make it better, but make it worse for people, but good for profits.

Please stop the privatization of Medicare, this from someone on the front lines. Perhaps I am not a business guru, but Medicare as is, run by the government, is far more efficient, Medicare's administration rates are far better than the ilk from for-profit DCEs or insurance companies.

I am firmly against profit over patients.

Pat Kanzler, R.N.

LETTER SUBMITTED BY DR. RICHARD MCGOWAN

As a physician who cares for Medicare beneficiaries and as an American citizen who someday may rely on the coverage of Medicare as a patient, please accept my statement against CMS Innovation Centers' dangerous and deceptive practice of privatizing Medicare through the use of the for-profit intermediaries known as Direct Contracting Entities or DCEs.

Not only are DCEs threatening to bankrupt traditional Medicare, which if anything needs to be expanded to cover more people and more services right now, it is doing so without the consent of patients who are automatically being enrolled into these third party management plans.

DCEs incentive placing harmful restrictions on the care delivered to Medicare beneficiaries so that managers can profit from money not spent on patient care. The practice of "up coding," or making patients appear sicker on paper than they actually are to procure more funds from Medicare undermines the mission of Medicare and leads to further fraud and abuse of our health-care system at the expense of patient care, for the benefit of Wall Street profiteers.

This is completely shameful, violating the trust of Medicare beneficiaries for our most popular health program in this country and is occurring without Congressional authorization.

I urge CMS, Secretary Xavier Becerra, members of the Senate Finance Committee and the Subcommittee on Fiscal Responsibility and Economic Growth to act to end Direct Contracting Entities and the fraudulent abuse of the public trust immediately, seek to provide recourse to patients who have already been defrauded and harmed by this practice and overhaul the Center of Innovation at CMS so deceptive practices like these do not occur in the future.

Sincerely,

Dr. Richard McGowan

LETTER SUBMITTED BY ELLEN MULLARKEY

Dear Senators Warren and Cassidy,

I have heard this analogy about health care insurance that I would like to share with you in case you have not used it.

When you go out for a dinner reservation would you be willing to wait a long time to be seated at your table? Once seated, would you like to find out that you only have 5–10 minutes to eat? Would you like to be given a bill that includes additional charges from a middleman who pays the restaurant for you, but refuses to give you an appetizer or a desert?

I think that might be an easier way to present insurance to people.

Thank you for the hard work you are doing for this committee, which was apparent in the meeting today. I am a Family Nurse Practitioner with a doctorate nursing from Georgetown. I worked for 5 years at Optum dealing with Medicare Advantage patients. Optum would hold training sessions on how to "code" for the visit. This also included the correct documentation to verify the code. They were more worried about your coding than patient care.

One point you did not have time to address is the short time that providers are allowed to visit patients. Right now you are expected to see a patient in 5–10 minutes. That is criminal. You can't listen to heart sounds, review medications, and document in that time frame. As a nurse practitioner at Optum we were allowed to spend 15 minutes with patients. My office had two other physicians that I worked with. We had a large flow-chart in one office that kept track of the hospital admissions of our patients for the month. Mine was always less, even when adjusted at a visits per provider rate. The doctors I worked with were very good and I believe that the reason for my lower admission rate is that I spent more time with the patients, they trusted me. So please, allow providers to spend 15 minutes at least, with a patient.

I have worked in Ontario, Canada as a critical care nurse and my level of satisfaction with my job was much better because I didn't have to worry about my patient being charged for an extra syringe. In Ontario, you have to lose weight before they do knee surgery; control your blood sugar before you start breast cancer treatment. These patients have skin in the game and it leads to better outcomes. Although I paid higher taxes in Ontario, I did not have to pay for health insurance, which made my take home pay the same. I never had to pay out of pocket for a surgery or a provider visit. None of my neighbors were bankrupt because of health bills.

Dr. Cassidy is correct when he states that consumers need to understand the choices they are making. Every large healthcare organization I have worked for has "Information sessions" for choosing your health benefits. When we can't figure it out-the country has a problem!

It was mentioned several times that there are some programs that actually give patients money back every month. The patients that I have seen get those programs are using the extra $100.00 for other basic needs. These plans have lower coverage and you need to save the $100.00 to pay the extra monthly costs associated with your medications or equipment that is not covered. Those plans are for the healthy not for anyone who is on medicare.

The comment about getting an air conditioner and a TV for a man boils down to the fact that your health is based on your zip code and not your genetic code. Social determinants of health must be addressed but I assume that is outside of your committee.

The Society of Actuaries published a report in 2020 that compared a new model of primary care "Direct Patient Care" to "Fee for Service" and the Direct Patient Care model was found to be more cost effective. There was a 53.6% reduction in outpatient ER visits and a 22.2% reduction in outpatient procedures. I am in the process of starting my own practice under this model. It is cheaper than concierge care and more like a gym membership. I will not take insurance but I will provide the paperwork for the patient to submit the bill to their insurance. The initial cost is a $150.00 visit where I come to your home/office for 50 minutes. One gets 12, 30-minute telemedicine visits a year for price set by your age.

18–24 yrs $65.00 a month.
25–50 yrs $75.00 a month.
51–64 yrs $80.00 a month.
65 and older $85.00 a month.

Many people have jobs without insurance so I am going to see if this model works or not. I will encourage everyone to have catastrophic insurance or a wrap around plan.

Thank you again for all of your work in finding solutions to improve access to health care.

Ellen Mullarkey, DNP, APRN, FNP–BC

LETTER SUBMITTED BY DIANE J. PETERSON, ET AL.

Regarding the February 2, 2022, testimony delivered by Dr. Susan Rogers of Physicians for a National Health Program, we agreed that Congress and/or President Biden must halt the intensification of health care chaos posed by Direct Contracting Entities.

These Direct Contracting Entities are detrimental to the welfare of American patients and an affront to those of us whose payroll taxes have funded the Medicare and Medicaid programs.

We ask Congress and/or President Biden to nullify the control Direct Contracting Entities currently have over Medicare patients and American health-care delivery.

We further desire strong preventive measures on any further operations they may attempt to control or "benefit" patients or health care providers.

We are politically engaged Minnesotans who have coordinated our activism on health care policy since October 2015. We promote accountability in the Minnesota Medicaid program and we support Traditional Medicare.

Diane J. Peterson, St. Paul
John Kolstad, Minneapolis
Dawn Tuveson, Woodbury
Paula Overby, Eagan
Allan Hancock, Brooklyn Center
Julie Gelle, Sandstone
Paul Busch, St. Paul
Rick Rayburn, Willow River
Sharon Schmidt, Savage
Paul Tuveson, Woodbury
Charles Stander, St. Paul
Elly Clark, North Oaks
Carol Mellom, St. Paul
Scott Killerud, Willow River
Jim Brown, Mankato

LETTER SUBMITTED BY SHARON SCHMIDT AND DIANE J. PETERSON

In addition to completely opposing Direct Contracting Entities which have begun to do Medicare Direct Contracting, we object to the existence of the Center for Medicare and Medicaid Innovation.

That agency undermines the principle of government accountability because it exists outside the control of Congress. Therefore, we call for the abolishment of the Center for Medicare and Medicaid Innovation because it allows Medicare Direct Contracting by investors interested in purely financial gain.

Medicare Direct Contracting, and the parent organization for that abomination, the Center for Medicare and Medicaid Innovation, should be dissolved immediately and similar schemes should be outlawed in our nation.

Sharon Schmidt
Diane J. Peterson

STATEMENT SUBMITTED BY PETER SHAPIRO

My name is Peter Shapiro. I am on the board of Healthy California Now and a delegate to the Alameda Labor Council, representing the California Alliance for Retired Americans. I am reluctantly enrolled in a Medicare Advantage plan, one that I would have dropped in a New York minute had Congress seen fit to expand traditional Medicare to include dental, vision, and hearing. Unfortunately, I could not pay for any of those things out of pocket without significant financial hardship. Hearing aids in particular are expensive and must be periodically replaced.

At least my decision to enroll in Medicare Advantage, however reluctant, was one I was allowed to make for myself. The prospect of seniors like myself being moved from traditional Medicare into a private insurance plan without even being informed, let alone consulted, is appalling to me. But the real problem is the rationale for this move, which is uninformed at best and disingenuous at worst.

It is widely acknowledged that health care costs in this country are out of control and that, by many indicators, our health care outcomes are significantly poorer than those of other countries that spend far less money. I believe there is a fairly simple explanation for this: the United States is unusual if not unique its reliance on private insurance and the extent to which market incentives drive the delivery of health care.

Yet rather than attacking the problem at its source, we have allowed ourselves to be drawn into a specious debate over how providers should be compensated. More specifically, the use of fee for service in Medicare payments has been targeted as the main cost driver in our system, or at least the main one worth targeting. The assumption is that fee for service encourages unnecessary treatment, and people are actually going to the doctor more than they should. Diverting Medicare patients into

private Accountable Care Organizations paid through risk-adjusted capitation is being proposed as a solution.

I make no claims to expertise, but any reasonably well-informed person can question whether this notion stands up under scrutiny. The problem with our health care system is not that people are getting too much treatment; it's that too many of us can't get it when we need it. Falling life expectancy and unacceptably high rates of infant and maternal mortality ought to tell us as much.

The Committee might consider the review of Japan's health care system in a recent report of the Commonwealth Fund. Japan has a single payer system; the role of private insurance is purely supplemental and, from a financial point of view, fairly insignificant. Without exception, providers are compensated on a fee for service basis. People in Japan are actually more likely to seek medical treatment than people in this country. Yet their system costs far less than ours, and by most metrics its outcomes are better.

The problem with capitation in a competitive, market driven system is that it encourages health plans to look for ways to pick and choose their patients in order to maximize profits. Those who cost more money to treat are discouraged from enrolling; those who are healthier are given a host of enticements to attract their business. The result is a system that is inherently discriminatory and tends to divert resources away from where they are most needed.

In recognition of this, repeated attempts have been made to devise a risk adjustment algorithm that compensates appropriately for patients who will likely prove more costly to treat. Several studies are available that look at how these attempts have worked out in practice. All of them concluded that they were largely useless at achieving their stated goal. Computer science has not yet developed an algorithm that can effectively substitute for clinical judgment.

What Medicare's experiments in risk adjustment have done, however, is impose new burdens of documentation upon primary care physicians, who often lack the resources (to say nothing of the time) to manage the additional paperwork. Worse, it has encouraged the use of upcoding to "game" the system. Kaiser Foundation Health Plan is currently being investigated by the Justice Department for some particularly egregious behavior in this regard, claiming treatments that were not only unnecessary but apparently never even took place.

As someone who strongly believes in Medicare as originally conceived by Congress as a model of how to deliver health care efficiently and equitably, I am deeply disturbed by the growing trend toward privatization of a precious public resource. I find it troubling that the Direct Contracting Entities which are being set up to channel Medicare enrollees into private plans have attracted the attention of private equity firms that have no history of engagement with health care delivery but are ever on the alert for lucrative new investment opportunities.

Instead of encouraging this trend, Congress should rededicate itself to expanding Medicare coverage and access, so that seniors like myself who have spent their working lifetimes paying into the system will no longer need to supplement their coverage with private plans.

3M HEALTH INFORMATION SYSTEMS, INC.
1425 K Street, NW, Suite 300
Washington DC 20005

Chairwoman Warren, Ranking Senator Cassidy, M.D., and distinguished Members of the Subcommittee, thank you for the opportunity to submit comments for the record for this important hearing on the Medicare Hospital Insurance Trust Fund and the Future of Medicare Financing. Nearly 40 years ago, 3M supported monumental steps to shore up the Medicare Trust Fund to protect vital coverage for America's seniors, and we remain committed to supporting efforts to protect the solvency and effectiveness of the program for its beneficiaries today. Building on the integrity of solid, time-tested ways to reduce cost and quality variation, we recommend five ways for Medicare to broaden quality oversight initiatives, reduce performance variation, and extend the solvency of this important healthcare program.

What Has Worked: Time-Tested and Proven Methods to Drive Efficiency and Quality

Some 40 years ago, the Medicare Part A hospital insurance trust was approaching insolvency.[1] In a bipartisan fashion, Congress and the Administration came together and implemented the Medicare Inpatient Prospective Payment System (IPPS) for fiscal year 1984. Adoption of the IPPS program reduced annual expenditures for hospital care in 1990 by $18 billion against originally projected spending at the time of implementation—some $37 billion in today's dollars and representing a 20% decrease in annual hospital Medicare expenditures.[2]

After 40 years of examining the impacts of IPPS, two key elements are credited for enabling its success—elements that can and should be replicated again today. These two important factors include:

- Focus on Variation. Before the implementation of IPPS, there was a sixfold variation in the average amount Medicare paid to individual hospitals for the treatment of an acute myocardial infarction (heart attack) with no plausible justification for that level of variation.[3] Such variation meant that opportunities for improvement existed, thereby creating the potential for cost savings. A major objective of IPPS was the elimination of variation in the cost per hospital admission. Basing payment on the national cost per inpatient stay essentially standardized payment across hospitals and eliminated variation in payments that had no plausible justification.
- Create Clear Financial Incentives for Efficiency. When IPPS was implemented, it was done in a budget neutral fashion. There were no reductions in payment levels associated with IPPS. IPPS used the Diagnosis Related Groups (DRGs) patient classification system was used as the unit of payment in IPPS. A fixed DRG based payment bundle that included all services provided during an inpatient hospital stay was used to create the financial incentive for the efficient and effective use of hospital resources. Savings came from reforming *how* hospitals were paid. Hospitals responded to the financial incentives and lowering the cost of hospital care, thereby allowing a dramatic reduction in the annual hospital inflation adjustment factor without creating a financial crisis for hospitals.

The DRGs that are the underpinning of the IPPS were developed as a *management tool* for hospitals. They allowed hospitals "motivate physicians to use hospital and other resources economically"[4] and "document the relationship between medical and administrative decisions."[5] The DRGs brought industrial methods of cost and quality control to the hospital industry to create the basis for "control of the production process."[6]

Clear Incentives—Three Components. To be an effective management tool requires them to be based on a clinically credible language of performance improvement that meets three essential requirements:

➢ *Clinically credible and actionable:* The determination of performance should be limited to those beneficiaries whose clinical circumstances indicate that there is reasonable likelihood that the quality problem or delivery system failure could have been prevented (*e.g.,* readmission for a post op wound infection following orthopedic surgery). Improved performance requires real behavior change so the performance measures must be clinically credible and actionable. It is counter-productive for achieving behavior change if a performance measure includes beneficiaries over which a provider has no influence or control *(e.g.,* readmission for an appendectomy following orthopedic surgery).

---

[1] Board of Trustees of the United States Federal Hospital Trust Fund. 1982 Annual report of the board of Trustees of the federal hospital insurance trust fund. House document 97–166, 97th Congress, 2nd session. Washington, DC: Government Printing Office, 1982.

[2] Russell, Manning. (1989). "The Effects of Prospective Payment on Medicare Expenditures." *The New England Journal of Medicine,* 320(7).

[3] Schweiker R.S., *Hospital Prospective Payment for Medicare.* Report to Congress. December 1982.

[4] Enthoven. A.C. "Cutting costs without cutting the quality of care." *New England Journal of Medicine* 298(22):1230, June 1. 1978.

[5] Griffith, J.R., W. Hancock and F.C. Munson (eds.). *Cost Control in Hospitals,* p. 5. Ann Arbor: Health Administration Press. 1976.

[6] "AUTOGRP: An Interactive Computer System for the Analysis of Health Care Data," Mills, Fetter, Riedel, Averill, *Medical Care,* Vol. 14, No. 7, July 1976.

- ➢ *Comprehensive:* Successful quality improvement efforts require behavior changes that typically mean changes to organizational culture. Such cultural changes cannot occur in isolated areas but need to be organization-wide.[7] This means that the full scope of a performance measure, not just isolated examples, need to be included (*e.g.,* inclusion of all types of complications as opposed to inclusion of just a few types of complications or "never events").
- ➢ *Language of performance:* The DRGs were the method of risk adjustment in IPPS. The categorical structure of the DRGs allowed performance benchmarks (the DRG price) to be set for each risk category (each DRG), thereby creating the language of performance expectations. The use of real-world benchmarks for judging performance is essential because even the best performing hospitals will have a residual rate of quality and delivery system failures. Similarly, the risk adjustment of the performance measures in the hospital episode of care payment bundle should be based on discrete clinically credible risk categories that allow hospital performance in each risk category to be compared to national benchmarks thereby creating a clinically credible language of performance expectations.

These three requirements may seem obvious, but they have been rarely met in existing pay for performance or value-based payment systems. For example, the current payment adjustment for Medicare hospital readmissions is limited to just a few clinical areas and is all-cause so readmissions over which a hospital has no reasonable control are included.[8] The Medicare hospital value based purchasing system has largely failed to produce significant savings or improve quality of care[9] because it has been based on a constantly changing multitude of performance measures that are combined into a payment adjustment that is complex and difficult for hospitals and beneficiaries to understand. Furthermore, risk adjustment has been expressed in the form of mathematical equations that are not inherently understandable and do not represent a clinically credible language of performance.

Next Steps: Transformational Reforms Across Medicare to Drive Performance and Reduce Wasteful Spending for Another 40 Years

The rapid success of IPPS in controlling Medicare Hospital expenditures did have an unintended consequence. It removed the urgency to move to the next phase of hospital incentive-based cost control. When IPPS was proposed, HHS acknowledged that payment by DRG controlled the unit cost of a hospital admission but provided no incentives to control the volume of admissions or other services related to a hospitalization.[10] Some forty years ago, the adoption and growth of Medicare Advantage was not predicted, nor was the advancements in technology and care that has lead to the expansion of care provision in ambulatory settings.

3M recommends the following five steps to bring the lessons learned from the past 40 years to drive transformational performance and outcomes improvements today across all of Medicare.

- Expanding the DRG Inpatient Payment Bundle to a Hospital Episode of Care Payment Bundle. A fundamental lesson from IPPS is that bundled payments can be used to create the financial incentive for the efficient and effective use of hospital resources. Importantly, successful bundled payment systems must simultaneously be a management tool that can facilitate behavior change and performance improvement with an effective communication of incentives in the system. As noted by CMS in 2001, "the success of any payment system that is predicated on providing incentives for cost control is almost totally dependent on the effectiveness with which the incentives are communicated."[11] The IPPS DRGs created a language that linked the clinical and financial aspects of care, enabling the effective communication of cost containment incentives across the entire hospital—essentially, a "product with a price."

The next phase of provider incentive-based cost control needs to incorporate incentives to control the volume and variability of services associated with a hospitalization. This requires expansion of payment bundles to include care decisions and serv-

---

[7] Walker, B., Soule, and S., "Changing Company Culture Requires a Movement, Not a Mandate," *Harvard Business Review,* June 20, 2017.

[8] Averill, R., Goldfield, N., and Hughes, J.S., "Medicare Payment Penalties for Unrelated Readmissions Require Second Look," *HFMA,* October 2013, pp. 96–98.

[9] *https://www.gao.gov/products/gao-16-9.*

[10] Schweiker R.S., *Hospital Prospective Payment for Medicare.* Report to Congress. December 1982.

[11] Federal Register. Vol. 66, No. 87, Proposed Rules, May 4, 2001. p. 22668.

ices prior to and after the inpatient stay, essentially transforming the inpatient DRG payment bundle to a *hospital episode of care payment bundle.* Poor performance on the measures in a hospital episode of care payment bundle represent unnecessary or preventable quality and delivery system failures.

- Value-Based Care that Improves Patient Outcomes and Helps Reduce Beneficiary Expenses. In a successful, comprehensive value-based program, beneficiaries have some basic expectations from the care and care management they are receiving:[12]
    - Avoidance of unnecessary hospital admissions.
    - Prevention against avoidable complications or mortality.
    - Avoidance of unplanned readmissions or ED visits after hospital discharge.
    - Provision of in-home post-discharge care rather than needing residential post-acute care facility after hospital discharge.
    - Care provision that yields results similar quality outcomes compared to like- patients with similar health status and burden of illness.

Substantial performance variation across care provision of these beneficiary expectations across providers and plans equate to opportunities for improvement exist that can substantively improve quality of care and delivery system effectiveness for beneficiaries. Substantial patient outcome variation between patients with similar illness burdens and risk scores identifies potential areas to target to reduce inequities within the healthcare system or unmet social determinants of health (SDOH), which are conditions affecting health and quality-of-life-risks and outcomes in the places where people live, learn, work, and play.

Providers and Medicare Advantage plans can influence or have direct control over performance for each of these basic beneficiary expectations and failure to meet those expectations is indicative of a delivery or care management system that is not functioning as intended. An effective outcomes-based program should target these key drivers of volume and variability, including:

- inpatient and outpatient complications;
- readmissions;
- admissions through the ED;
- return emergency department visits;
- surgical mortality;
- admissions to a PAC facility; and
- site neutral shift of procedures to outpatient surgery.

Fortunately, many of these performance measures are effectively in use today, such as those evaluating readmissions [13] and complications [14] and methods of risk adjustment [15] that meet these requirements. These measures are successfully being utilized in the payment systems of numerous state Medicaids and other and other payers. For example:

- **Maryland.** An incentive payment system related to complications in Maryland has yielded a reduction in complications of over 50%.[16]
- **New York.** The recently released final evaluation by an independent evaluator of New York Medicaid's Delivery System Reform Incentive Payment (DSRIP) program found that avoidable hospital use was significantly reduced with potentially avoidable readmission rates down by over 18% and potentially avoidable admission rates down by over 26%.[17] It also reported a 3.5% reduction in potentially avoidable ER visits. Ultimately, these ef-

---

[12] Millwee, B., Goldfield, N., Averill R., and Hughes, J.S., "Payment System Reform: One State's Journey," *Journal of Ambulatory Care Management,* Vol. 36 #3, pp. 198–208.

[13] Goldfield, N., McCullough, E., Hughes, J., Tang, A., Eastman, B., Rawlins, L., and Averill, R. "Identifying potentially preventable readmissions." *Health Care Finance Rev.* 2008;30(1):75–91.

[14] Hughes, J.S., Averill, R.F., Goldfield, N.I., Gay, J.C., Muldoon, J., McCullough, E., and Xiang, J. "Identifying potentially preventable complications using a present on admission indicator." *Health Care Finance Rev.* 2006;27(3):63–82

[15] Averill, R.F., Goldfield, N.I., Muldoon, J., Steinbeck, B.A., and Grant, T.M. "A closer look at All-Patient Refined DRGs." *J AHIMA.* 2002;73(1):46–49.

[16] Health Services Cost Review Commission, Baltimore, MD. (2016, January 13). *Final Recommendation for Modifying the Maryland Hospital-Acquired Conditions Program for FY 2018.* Retrieved from *https://hscrc.maryland.gov/documents/HSCRC_Initiatives/QualityImprovement/MHAC/RY2018/MHAC-Final-Rec-RY18.pdf.*

[17] Blueprint for Change: DSRIP's Independent Evaluator Finds Program a Success, Goals Reached—HSG.

forts help stabilize NY Medicaid managed care spending down from its annual double digit increase before the program started to a roughly 1.9% increase over the 5 years of the program. As stated in the December 14th letter from Danielle Daly, Director Division of Demonstration Monitoring and Evaluation, to Brett Friedman, Acting State Medicaid Director, NYSDOH. "The report also presented a thorough examination of lessons learned from the DSRIP program that will help support future delivery system reform and quality improvement projects both in New York and elsewhere."

- **Texas.** The Texas Medicaid public reporting website[18] allows enrollees to see overall and regional performance, specific health plan performance-overall and by region, over time periods to make informed decisions on where to enroll or go for services. Texas Medicaid's Pay for Quality program uses potentially avoidable admissions, readmissions, and complications performance data to set efficiency payments to plans and hospitals and redistribute up to $225M annually based on performance metrics. In addition, under Texas' new quality-based auto-enrollment program, enrollees are directed to higher value health plans using the outcomes measures as part of that value scoring process.

- Aligning Incentives Across All Medicare. Lessons from IPPS and these states can inform how to drive further value in an outcomes-based quality program, provide greater insights for patients, and reduce healthcare system spending. For example, measures used successfully across states for their value-based care programs could be used to update both the Medicare Hospital Readmissions Reduction Program (HRRP) and Hospital Acquired Condition Reduction Program (HAC) as well as the Medicare Advantage STARS ratings with greater insights into provider and plan outcomes performance. This would provide consistency for beneficiaries as well as providers who are often challenged with conflicting incentives across payers.
- Matching Today's Shifts in Patient Care. Where care is provided today is significantly different than it was forty years ago. Thanks to new treatment approaches, technology advancements, financial incentives, and patient preferences,[19] there has been significant growth in ambulatory services, including hospital outpatient departments (HOPDs), ambulatory surgery centers (ASCs), physician offices, urgent care centers, and more. Medicare payments to providers can vary significantly depending on the site where the service is provided. For example, the same procedure performed as a hospital inpatient, in a HOPD or an ASC have different payment levels and different impacts on beneficiary financial liability. Similarly, medical services provided in an HOPD and a physician office have different payment levels. Site neutral payments can be an effective means of reducing Medicare expenditures, but steps will be needed to reflect the resource requirements met in each type of care setting. In addition, an inpatient/outpatient site neutral payment system would require the identification of equivalent categories of procedures in both the inpatient and outpatient setting. The inherent complexity of inpatient care, especially for multiple procedures during a hospital stay, and the significant differences between the inpatient coding system for procedures (ICD–10–PCS) and the outpatient coding system for procedures (CPT) present a challenge for creating equivalent categories of procedures. However, research has demonstrated that identification of equivalent categories of procedures in both the inpatient and outpatient setting can be done for a wide range of procedures.[20]
- Looking at Clinical and Social Risk Together. To better understand health equity and social influencers of health, clinical and social risks should not be considered in isolation. Rather, clinical and social risks should be viewed together to get a complete patient picture.
  - Overlaying clinical and social risks helps to identify high risk patients to facilitate prevention and care management to drive health and avoid catastrophic health event.

---

[18] Texas Healthcare Learning Collaborative *(https://thlcportal.com/home).*

[19] Healthcare Consumerism Driving Growth in Outpatient Services *(https://revcycle intelligence.com/).*

[20] *the-shift-to-outpatient-surgery-geographic-variation-and-site-neutral-payments.pdf (3m.com)*

- It allows for an effective communication through a language for payers and providers to use to describe and understand patient burden of illness and expected resource needs.
- It sets up a way to monitor the effectiveness of care provision, identify instances of poor care delivery, and surface areas for collaboration with community-based organizations.

Payers and providers often feel like they are drowning in data—but there are ways to improve data collection via existing data streams to make it all more meaningful and impactful. There is a need for social risk data to be brought into the medical record, not through an additional or burdensome reporting scheme, but in a structured, organized way to enable insights into the interactions between clinical and social risk.

Capturing SDOH related information with SDOH z codes is one important step to begin capturing and using social risk information. SDOH z codes can inform the allocation of resources to meet the needs identified, including funding essential to the primary care infrastructure and coordinating with community-based organizations. Importantly, we believe it is critical to adjust for SDOH on top of a payment system and not bury it within risk adjustment. Inclusion of factors relating to equity or disparities in the method of risk adjustment increases the chance of perpetuating structural biases because performance differences across racial subgroups will be hidden in the analysis, as discussed above. Such differences in performance need to be highlighted, not eliminated by risk adjusting for them. Including race in the risk adjustment could essentially perpetuate low performance expectations for some racial groups.

Summary

The Medicare Program faces another transformational opportunity to build off lessons learned to extend the life of the program and lives of the people it serves. Medicare's comprehensive inpatient payment reforms some 40 years ago provide the playbook for today through a singular focus on efficiency.

To do this today, Medicare must once again focus on variation and create clear financial incentives for efficiency. To create clear incentives, performance measures employed should be comprehensive, clinically credible and actionable, and based on a language of performance. To be effective, a limited list of outcomes-based measures should be used that target key drivers of volume and variability during a hospital episode.

Specifically, 3M recommends

1. Expanding the DRG inpatient payment bundle be expanded to a hospital episode of care payment bundle that includes care decisions and services prior to and after the inpatient stay,
2. Using value-based care programs based on tested and proven measures that focus on the nexus of quality and care outcomes as well as help surface instances of health inequities or presence of social determinants of health,
3. Aligning incentives across all Medicare offerings,
4. Updating payment models to match today's shifts in patient site of care choices, and
5. Incentivizing better capture and use of social data into the current data stream.

Bottom line, transformational changes to payment and quality programs will ensure beneficiaries, regardless of whether they choose traditional fee-for-service Medicare or Medicare Advantage or whether they seek care inside a hospital, ambulatory provider, or even through telehealth, receive value-driven care that improves or maintains their health and reduces unnecessary spending by beneficiary or Medicare.

Thank you again for this opportunity to submit comments. We look forward to working with the Committee on ensuring the solvency of the Medicare program for decades to come. We would be happy to present additional findings and would welcome the opportunity to answer any questions. Please contact Megan Ivory Carr at mmivory@mmm.com for any additional information.

Appendix—Additional Detail Related to Performance Measures that Should be Included in a Hospital Episode of Care Payment Bundle

Hospital Admissions. With respect to inpatient admissions, hospitals can influence or have direct control over admission through the emergency department and the surgical site of service. While ED costs for patients who are admitted are already bundled into the DRG payment amount, the decision to admit has a much larger

financial impact (over 70% of hospital admission are through the ED). Even though there are policies aimed at limiting short stays such as the two midnight rule,[21] there remains wide variation across hospitals in the rate of low severity medical admissions from the ED.[22] With technological advances the scope of procedures that can be performed in a lower cost outpatient setting (site neutral procedures) has steadily increased. There is wide variation across hospitals in rate at which site neutral procedures are being performed in an outpatient setting.[23]

Complications and Mortality. Post admission complications that occur during a hospital stay can result in the assignment of a higher paying DRG. In addition, complications during an inpatient stay are associated with an increase in readmissions.[24] For surgical patients there is a reasonable expectation that a patient will survive the procedure. The majority of surgical mortality occurs after discharge. Therefore, 30-day post procedure mortality is a more appropriate mortality measure than during the admission in which the procedure was performed. There is wide variation across hospitals in the inpatient complication rate[25] and post procedure mortality rate.[26]

Unplanned Readmissions and Post Discharge ED Visits. There is wide variation across hospitals in the readmission rate and post discharge ED visit rate.[27] Readmissions have a direct impact on the overall hospitalization rate and any visit to the ED can result in a hospital admission.

Residential Post Acute Care (PAC) Facility Admissions. PAC site of service decisions and PAC quality of care problems have a substantial impact on the volume of services related to a hospital admission. Hospitals have influence over the need for PAC facility admission and the PAC facility selected. Poor quality in a PAC facility can lead to an increase in hospital admissions and ED visits. There is wide variation across hospitals in the rate at which patients are discharge to a PAC residential facility.[28] The inclusion performance measures related to admissions through the ED, site neutral shift of procedures to outpatient surgery, inpatient complications, surgical mortality, readmissions, return emergency department and admissions to a PAC facility would expand the IPPS payment bundle to a hospital episode of care payment bundle that aligns with beneficiary expectations.

Determining the hospital episode of care bundled payment. A single DRG like hospital episode of care payment bundle amount would not be feasible. The diversity of services included in the hospital episode of care payment bundle makes it difficult to establish a stable all-inclusive hospital episode of care payment amount.[29] Instead, performance variation in these performance measures can be used to adjust the standard DRG payment amount, thereby creating incentives that are equivalent to a hospital episode of care payment bundle. With the exception of surgical mortality, all these performance measures have a known financial impact based on the existing payment system (*e.g.,* the cost a readmission is known). This avoids use of arbitrary payment adjustment factors. The adjustment factor for each performance measure would be determined by comparing performance to national risk adjusted benchmarks and adjusting IPPS payments based on variation from the national benchmarks thereby, creating the equivalent of a hospital episode of care bundle. Such an approach would also provide hospitals more precise comparative management information than a single hospital episode of care payment amount. While the performance measures included in the hospital episode of care payment bundle may appear straightforward, the implementation details are critically important. CMS has been moving in the direction of bundled episode payments with payment adjustments based on complications and readmission performance. However, the implementation by CMS of these payment adjustments has been narrow, not clinically

---

[21] *https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0.*
[22] *3m-his-medicare-regional-variation-case-study.pdf.*
[23] *the-shift-to-outpatient-surgery-geographic-variation-and-site-neutral-payments.pdf (3m.com).*
[24] *3m-his-medicare-regional-variation-case-study.pdf.*
[25] *3m-his-medicare-regional-variation-case-study.pdf.*
[26] Averill, R.F., Fuller, R.L., and Mills, R.E. (2020, September). "Surgical mortality as a measure of hospital quality." 3M Clinical and Economic Research. *https://multimedia.3m.com/mws/media/2044672O/surgical-mortality-hospital-quality.pdf.*
[27] *3m-his-medicare-regional-variation-case-study.pdf.*
[28] Averill, R.F., Fuller, R.L., and Mills, R.E. (2021, June). "Geographic variation in post-acute care facility-admissions." 3M Clinical and Economic Research. *https://multimedia.3m.com/mws/media/2051382O/report-geographic-variation-in-post-acutecare-facility-admissions.pdf.*
[29] Vertrees, J., Averill, R., Eisenhandler, J., Quain, A., and Switalski, J. "Bundling Post-Acute Care Services into MS–DRG Payments." *Medicare Medicaid Res Rev.* 2013;3(3):E1–E19.

credible and actionable, and has not significantly impacted system-wide performance.

**Note on Beneficiary Expenses.* Incentives for performance improvement can be strengthened by beneficiary engagement in selecting providers based on reported performance. Current IPPS incentives are limited to the hospital with virtually no financial consequences for beneficiaries. As a byproduct of a hospital episode of care payment bundle, there will be a more direct financial impact on beneficiaries with fewer post-acute care expenses that usually translate to less out-of-pocket expenses. Where possible, the expansion to a hospital episode of care payment bundle should focus on performance measures that align with beneficiary expectations for the functioning of the delivery system.

LETTER SUBMITTED BY ANDREW TUCK

U.S. Senate
Committee on Finance
Subcommittee on Fiscal Responsibility and Economic Growth

Dear Members of the Senate Finance subcommittee,

Thank you for holding and televising the hearing on February 2nd, that let more people know about the DCE programs and what these entities will do to end Traditional Medicare. I am writing to URGE you to stop the DCE pilot project.

As someone who has been insured by Traditional Medicare, I have never had to fear that my doctors would be tempted by self-interest to withhold from me needed treatment or diagnostic tests to keep more money for themselves. DCE introduces conflicts of interest into the medical care for patients. It puts my trust in my doctors in danger. It introduces a profit-making entity into the relationship between doctor and patient.

While DCEs were set up to encourage doctors to form DCEs, it turns out the groups running the DCEs are financial and investment companies. We know what happened to the rationing and quality of care with Medicare Advantage plans.

Traditional Medicare allows a relationship of mutual respect between doctor and patient. If you allow DCEs to continue, you will have betrayed the promise of high quality and available medical care which has been promised to us in our old age. Don't destroy the trust we had that Traditional Medicare, a compact between patient and CMS, would always be there, and that 98% of allocated funds will go to patient care. Please stop the DCE program and save Traditional Medicare as we know it.

Andrew Tuck

LETTER SUBMITTED BY CAROL AND RICHARD VAN DEUSEN

I had a doctor for 30 years who retired early because practicing medicine was no longer possible for him. The profession he felt moved from being a profession to a business. He was a wonderful doctor and all he wanted to do was to serve his patients.

What I learned from listening to the hearing is that the future for traditional Medicare is changing. The plan is to enroll Seniors into a program run by a third party, run by an enterprise called Medicare Direct Contracting (DC). This is occurring unbeknownst to seniors who are affected.

I googled "DCE: Building new opportunities for healthcare organizations to enter into advanced value-based payment options with CMS".

It seems with Direct Contracting the field can attract investors and Hedge Fund managers having nothing to do with healthcare. They are private companies who want to make a profit. This will eliminate my trust that my doctor is recommending the best treatment for me, and not one that will make money for the group that owns the DCE.

With Medicare Advantage plans at least there are rules in place and they are owned by reputable insurance agencies that specialize in healthcare. DCEs not so.

Why must Healthcare in one of the richest countries in the world be a for-profit business and not the right of all citizens to receive the best healthcare?

Richard and Carol Van Deusen