

HEALTH CARE ENTITLEMENTS: THE ROAD FORWARD

HEARING BEFORE THE COMMITTEE ON FINANCE UNITED STATES SENATE ONE HUNDRED TWELFTH CONGRESS FIRST SESSION

JUNE 23, 2011



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HEALTH CARE ENTITLEMENTS: THE ROAD FORWARD

THURSDAY, JUNE 23, 2011

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:08 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Wyden, Nelson, Carper, Cardin, Hatch, Grassley, Thune, and Burr.

Also present: Democratic Staff: Russ Sullivan, Majority Staff Director; David Schwartz, Chief Health and Human Services Counsel; Tony Clapsis, Professional Staff; and Matt Kazan, Professional Staff. Republican Staff: Chris Campbell, Staff Director; Jay Khosla, Chief Health Counsel; and Stephanie Carlton, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order. Eleanor Roosevelt once said, "One's philosophy is not best expressed in words; it is expressed in the choices one makes . . . and the choices we make are ultimately our responsibility."

Today, the Finance Committee holds its fourth hearing examining the choices surrounding the budget and reducing the Federal deficit. This morning we focus on our health care choices, specifically, Medicare and Medicaid.

According to the Congressional Budget Office, 20 years ago, Medicare and Medicaid represented nearly 12.6 percent of total Federal spending. By 2035, that number is expected to grow to about 33 percent, almost triple.

For the continued health of Medicare and Medicaid and the health of our budget, we must address this growth.

What is causing these two programs to grow so fast? The most significant contributor is rising health care costs. For the past several decades, health care has been inefficient. Too often, physicians did not coordinate care. Seniors bounced between hospitals and nursing homes without being properly treated. Preventive services were underutilized. As a result, health care costs skyrocketed.

Another factor is our aging population. Nearly 80 million Americans are part of the baby boom. This year, they start to become eligible for Medicare. As a result, enrollment in Medicare will accelerate. In fact, 9,000 boomers turn 65 every day.

To slow the growth of Medicare and Medicaid, we have two choices: curb the growth of health care costs or shift the burden onto an aging population. Health reform represents the first of these two choices. The new law reins in costs and makes our health care system more efficient.

Reform begins to change how Medicare pays for health care. Instead of paying based on the number of services, Medicare now rewards doctors and hospitals for health care that delivers real results for patients. It pays for quality versus quantity. And, by investing in prevention, health reform saves money and saves lives.

Health reform laws will save us millions of taxpayer dollars by rooting out fraud and ending costly overpayments to private health insurance companies.

Thanks to these reforms, the health reform law resulted in the most significant deficit reduction in more than a decade. According to the nonpartisan Congressional Budget Office, health reform will reduce the deficit by \$210 billion in the next 10 years and by more than \$1 trillion in the decade that follows.

The House budget, on the other hand, makes the second choice. That budget ignores rising health care costs. Instead, it places the burden squarely onto the shoulders of seniors.

First, the House budget eliminates benefits that seniors count on to pay for the medicine they need. It reopens the Medicare Part D coverage gap, known as the donut hole, which health reform finally closed. Eliminating this coverage will force seniors to pay more for the prescription medicines they need.

Second, the House budget would cut more than \$700 billion from nursing homes and other Medicaid services. States would be handed a block grant to run their programs, with zero accountability. There would be no guarantee of nursing home access or other care for those who need it the most.

Finally, as the *Wall Street Journal* noted, the House budget would, quote, “end Medicare as we know it.”

The House budget would end Medicare’s guaranteed benefits. Instead, it would provide seniors with a voucher to purchase private insurance. Some call it premium support, others call it a voucher, but the effect is the same.

Under this system, private insurance companies would be able to charge more based on a person’s age, and the voucher would not come close to meeting seniors’ needs.

According to the CBO, most elderly people would pay more for their health care than they would pay under the current Medicare system.

How much more? The CBO estimates that under the House budget, the average 65-year-old would have to pay \$12,000 a year out of their own pocket just to receive the same benefits that Medicare offers today.

It is clear the health reform law and the House budget offer two distinct choices. Health reform makes our health care system more efficient. It reduces costs. The House budget shifts costs to seniors and the States.

So, let us make the right choices as we work to reduce the deficit, work together to protect seniors and reduce health care costs, and, also, continue to improve our health care system and improve

our budget. And, to heed Eleanor Roosevelt's advice, let us be responsible for the choices that we make.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

**OPENING STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH**

Senator HATCH. Thank you, Mr. Chairman.

I want to thank Senator Baucus for convening this hearing. The clock is ticking. Every day that passes that we do not act to rein in Federal spending and address our entitlement crisis leaves taxpayers exposed to unacceptable and unsustainable levels of debt. Simply doing nothing is not an option.

Let me just refer to this first chart. It is just the way it is. These problems are fundamental, and they do not fix themselves. We owe it to our seniors, children, and grandchildren to get off the sideline and act responsibly to fix this problem.

[The charts referred to by Senator Hatch appear in the appendix beginning on p. 52.]

Senator HATCH. Our fiscal situation is dire. We have now had 3 consecutive years with trillion-dollar deficits, and we have racked up \$14.5 trillion of debt. For any who doubted the magnitude of this crisis, the CBO confirmed it again yesterday. By 2035, our public debt will rise to 190 percent of gross domestic product if we do not get spending under control.

Now, think about that. Greece is currently, what, around 150 percent? We cannot allow this to happen. And right now we are on a glide path to Greece, a path with devastating implications for the liberty of taxpayers and the prosperity of our Nation, and perhaps a whole lot of other nations as well.

Admiral Michael Mullen has identified our current debt spiral as the greatest single threat to our national security. Now, it is hard for me to disagree with him. I do not.

The bottom line is that the storm is gathering, and a commitment to the entitlement status quo is a commitment to senior impoverishment and national bankruptcy.

Last year alone, total Medicare and Medicaid spending was \$800 billion. The longer we wait to address these programs' finances, the harder they will be to solve. And the time for courage, it seems to me, is now. This year, the first baby boomer will become eligible for Medicare. In 2010, there were 47 million Medicare beneficiaries alone, and, by 2031, it is projected that 80 million people will be Medicare-eligible. And as these retirees come online, government spending is going to mushroom. Just look at the chart putting it in perspective.

According to this year's Medicare trustee's report, Medicare is facing a \$38-trillion unfunded liability. Now, this number is so outlandish that I need to put it in perspective, and let us refer to this chart here.

The median household income is \$49,777 per year. The median home value is \$221,800, which we all know is the biggest asset most families will ever own. Yet, Medicare's unfunded liability stands at an astonishing \$353,350 per household.

So, even if an average family sold their home and gave up their income for an entire year, they would still not meet their share of this one entitlement obligation, and this is simply unacceptable.

Today, our three major entitlement programs, Medicare, Medicaid, and Social Security, account for 44 percent of non-interest Federal spending. But by 2085, these three entitlement programs could account for more than 60 percent, or two-thirds, of the Federal budget.

Now, we have seen this train coming down the tracks for some time. Yet, given the opportunity to address this fiscal imbalance in a responsible way, the President raided the already busted Medicare program. The Patient Protection and Affordable Care Act increased spending by \$2.6 trillion, created new entitlements and expanded old ones, and attempted to pay for all this by stripping Medicare of \$529 billion and raising taxes by over \$800 billion.

Guided by a political philosophy of never letting a crisis go to waste, this law has only helped to accelerate our current debt crisis.

To get Medicare spending under control, the President is going to have to lead. He is going to have to put national priorities over presidential politics and address entitlement spending.

Unfortunately, the President's solution is to grant power to a 15-member panel of bureaucrats that will decide how to spend taxpayer dollars and to determine what care senior citizens will receive.

Now, let me be 100-percent clear here. The Independent Payment Advisory Board, or IPAB, is not the solution to Medicare's upcoming bankruptcy. As bad as Medicare's financing is, it is only one contributor to the overall growing debt crisis.

Medicaid is also a growing problem on the Federal and State governments. The Medicaid program has grown far beyond its original purpose of being a safety net for the most vulnerable in our society.

Let me just refer to this chart here. As weak as Medicaid's financing already was, the health care law that passed over the objection of every Senate Republican, resulted in the largest expansion of Medicaid in history.

According to CMS, in 1966, there were only 4 million Medicaid enrollees, but by 2019, there will be 78 million. Almost one in four people in America will be on Medicaid. That ought to tell you something.

Just this week, we learned that the new health care law, through an unintended glitch, will actually expand Medicaid to an additional 3 million middle-class Americans making up to \$64,000 a year. Now, that is some glitch.

This mission creep is bankrupting the Federal Government. Washington will spend \$4.6 trillion on Medicaid over the next 10 years. That is a huge driver of our national debt.

To put it delicately, the new health care law certainly did not help. The Office of the Actuary at CMS estimates that the Medicaid expansion will cost Federal taxpayers \$735 billion over the next 10 years. That is just expansion. And cash-strapped States are also feeling the burden of the Medicaid entitlement.

The program consumes nearly 22 percent of the respective States' budgets today, and things are about to get a whole lot worse.

Let me refer to this chart number 4 to point out the Medicaid mandate on cash-strapped States. A Joint Congressional Committee report that I authored with Chairman Fred Upton of the House found that States are estimating they will have to spend another \$118 billion because of this new law.

To maintain these expansions will require cuts in other programs, like education, public safety, and health services. Many factors will continue to drive up Medicaid spending, such as the arduous maintenance of effort requirements, the administration-proposed rate regulations that set up new bureaucratic hurdles for States to manage their programs, and a court case before the Supreme Court this fall that could lead to a new wave of costly litigation.

There is simply no denying the obvious. Medicaid is in need of major reform. And, instead of centralizing power in the Nation's capitol, Congress should set broad guidelines and define budgets, but then empower the States to run their Medicaid programs in a manner consistent with the needs and the values of their own citizens.

Entitlement reform is not about cutting providers just for the sake of cutting. Medicare, Medicaid, and Social Security face real problems that demand structural changes.

Our citizens need these changes, and the markets are demanding them. Last winter, I heard a Democratic House member state that the Republicans won in November and, therefore, it is their job to fix entitlements.

Let me be very clear. It is all of our jobs to fix entitlements, and history will not look kindly on those who stood on the sidelines during the central debate about the very future of this Nation.

So, Senator Baucus, I want to thank you for convening this hearing today. I really do look forward to hearing from our witnesses and having a serious discussion about the need for meaningful reform, and I appreciate it.

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

The CHAIRMAN. Thank you, Senator, very much. I appreciate that.

Before I introduce our witnesses, I would like to say that Senator Kerry, a member of this committee, would like to introduce our first witness. He is now chairing the Foreign Relations Committee hearing.

He made it very clear to me personally that he wanted to be here to introduce you, Governor, but he cannot, and I am going to put his formal statement of introduction in the record.

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

Governor PATRICK. Thank you.

The CHAIRMAN. Our first witness is Governor Deval Patrick, the very esteemed Governor of the State of Massachusetts.

Our next witness will be the Honorable Ernest Lee Fletcher. I was going to tease you, Governor, and ask if you were going to

have an eventful arrival today or not. But I very much appreciate your coming today.

Our third witness is Bruce Vladeck. We are very happy to have you here. Mr. Vladeck, you have been very good in advising us in many, many ways, in many capacities, and we deeply thank you.

The same applies for our fourth witness, Douglas Holtz-Eakin. Doug, it is good seeing you here. Many of us have had the benefit of your counsel, advice, and your expertise, and we thank you for coming as well.

We will begin with you, Governor. You are first. And, as you know, we customarily ask witnesses to put their statement in the record—they will all be put in the record automatically—and just speak for about 5 or 6 minutes.

**STATEMENT OF HON. DEVAL PATRICK, GOVERNOR,
COMMONWEALTH OF MASSACHUSETTS, BOSTON, MA**

Governor PATRICK. Thank you, Mr. Chairman, Senator Hatch, members of the committee. Thank you very much for having me. And I will just try to summarize very briefly my more detailed written testimony.

I could not agree more with the opening statements about the importance of reforming Medicare and Medicaid to ensure their long-term sustainability and, also, reducing the national debt. Those are priorities that I share with members of the committee, with many other Governors, and with the Obama administration.

But how we reform these programs is about people, not about abstract policies. My comments come from that perspective, because I do my job with that perspective, as I know many of you do as well.

Thanks to the global economic collapse, nearly every State has been facing fiscal challenges similar to those being faced by the Federal Government, although at a different scale. In Massachusetts, we have cut spending, we have reformed government, we have used reserves and stimulus funds—thank you very much for that—and even raised our sales tax.

We also invested significantly in education, in health care, and in job creation, because we all know that educating our kids, securing people's health care, and putting people to work is the best way to build a better future.

Because we made those choices on both the spending and the revenue side, the Massachusetts economy today is now growing twice as fast as the Nation's economy. Our unemployment rate at 7.6 percent is well below the national average and declining. Our annual budgets have been responsible, balanced, and on time. And our bond rating has not only remained strong, but gotten stronger.

With that experience and those results to show for it, I am here to offer just three points. First, you do not have to end Medicaid or shrink the number of people that it serves to make it a sustainable program.

Over the last 5 years, through implementation of our own health care reform program in Massachusetts, we have extended reliable, quality health care to 98 percent of our residents, 99.8 percent of children. That has added about 1 percent to State spending.

Medicaid has been an important part of that strategy. And the flexibility exists today under the program to drive costs down through innovation in delivery and payment systems. Through an initiative on dual-eligibles, we expect to shave 2 percent off of the \$4 billion we spend on dual-eligibles this coming fiscal year.

And, when you consider that this population accounts for 40 percent of Medicaid costs program-wide, there are significant savings within reach.

I know some of my fellow Governors advocate for block-granting Medicaid. Block-granting may be good for the books, but it is bad for people, because the States cannot sustain the level of service or enrollment without Federal partnership, and the Governors advocating for block-granting know that.

Massachusetts could lose more than \$23 billion over 10 years if Medicaid moves to a block-grant formula. There is no way that our commonwealth, with a balance sheet even as strong as our own, would be able to absorb such a cost shift without seriously curtailing critical services and shedding thousands of jobs.

So my first point is that you should give the States the chance to use the flexibility under the current Medicaid program to drive down costs and harvest those savings. In fact, there are ways I think you can push us to innovate more.

Second, the Affordable Care Act helps, not hurts, the deficit picture. The simple, proven, common-sense logic is that better coverage leads to a healthier population, which leads to lower costs and greater economic competitiveness. The Congressional Budget Office estimates, as you know, that the Act will reduce the deficit by \$124 billion through 2019 and by more than \$1 trillion in the subsequent decade. In fact, there is more flexibility under the Affordable Care Act than there is even under the existing program.

Third, put revenues on the table. I know this is the point where most politicians run for cover, but it is time we faced up to this. Our Federal Government has been running two wars and a costly prescription drug benefit for nearly a decade using borrowed money.

Meanwhile, I know mom-and-pop stores and college students who pay more in taxes than corporations that are earning billions of dollars in revenue, and so do you.

Some of these loopholes ought to be closed. If we believe that the poor and disabled, the people Medicaid serves, should get adequate health care, it is only fair, it seems to me, to ask everyone to help close the gap other policy choices have created and exacerbated.

We need growth, and cuts alone will not grow the economy. We need to invest as well.

I want to work with you and with the other members of the Senate and the Congress and with the administration on ways to make these programs more modern, more sustainable, more effective. But I believe that we have to come at this from the perspective of the impact on people, not just on abstract policy. And in doing that, we keep our commitments to the American people—to seniors, to people with disabilities, to poor people—put America on a firmer fiscal footing, and build a better and stronger Nation for another generation to come.

Thank you very much, Mr. Chairman, for having me this morning.

[The prepared statement of Governor Patrick appears in the appendix.]

The CHAIRMAN. Thank you very much, Governor.
Governor Fletcher, you are next.

STATEMENT OF HON. ERNEST LEE FLETCHER, FORMER GOVERNOR, COMMONWEALTH OF KENTUCKY, LEXINGTON, KY

Governor FLETCHER. Chairman Baucus, Ranking Member Hatch, and other Senators of this august body, it is a great pleasure to be here to share a little of my opinion with you today.

It never fails when I come here that I have not lost the awe of the feeling of being in this great place, the Capital of this great Nation.

Regardless of party affiliation, we all know that our health care system needs reform. The Medicaid program is a prime example. According to CMS, taxpayers spent over \$404 billion on Medicaid last year, and projections have that doubling to \$840 billion by 2019.

The States' share of that spending will be almost \$330 billion. As with many other Governors, when I took office, I faced an empty rainy day fund and a staggering budgetary shortfall. It was quite a transition from my days here in the House Energy and Commerce Committee.

To solve our problems, we could not borrow from the future nor could we print money. Over the next 2 years, Governors face a total projected shortfall of \$175 billion, what the *Washington Post* has termed the most severe budget crisis since the Great Depression.

The \$151 billion in flexible emergency funding that the American Recovery and Reinvestment Act provided has expired, and now governments across the country are facing deep spending cuts or tax increases to balance their budgets.

New York Governor Andrew Cuomo called his State functionally bankrupt, and he proposed closing most of the \$10-billion budget gap by reducing funding for education and Medicaid.

Medicaid has grown to consume about 22 percent of State budgets and will consume \$4.6 trillion of Washington's budget over the next 10 years. Our national debt is mounting. In fact, if we do not change our course, in 6 years, we will be paying more on the national debt interest than we spend on Medicaid.

Governors also realize that Washington's budget situation prevents it from coming to the States' rescue again. Our Nation is in no position to bail out States. But what States and the Federal Government need to do, among other things, is take a hard look at how to control Medicaid spending.

To meet the challenges of Medicaid in Kentucky, we began the long waiver process. Fortunately, during that process, the Deficit Reduction Act passed in 2005. We were among the first States to take advantage of that Act. With this newfound liberty, we were free to focus on health care instead of navigating through the regulatory maze.

We established Kentucky Health Choices to increase service delivery choices for adults with the most difficult and challenging

problems. We introduced proven principles, including utilization and intense disease management.

Now, I am concerned that many of the flexibilities that allowed Governors to develop innovative win-win solutions are being taken away piece by piece. First, there was the maintenance of effort requirement to prohibit States from even making program integrity modernizations. Then there were the Medicaid expansions in the Patient Protection and Affordable Care Act, which put an unrealistic burden on the States. And now this administration's proposed set of new regulatory hurdles for States to navigate will make it increasingly difficult for States to manage spending on providers.

The Obama administration's health care overhaul allows little flexibility. It looks to Washington for the solutions rather than to those most familiar and close to the problems.

All of these issues make it increasingly difficult for Governors to focus on tailoring their Medicaid programs in ways that meet the needs of their citizens.

We must admit Medicaid does not work very well in its current condition. Not only do waste, fraud, and abuse plague our current system, but the program does not serve patients well. In some research, even patients without any insurance do better than those on Medicaid.

Some cancer mortality rates in Medicaid patients are 2 to 3 times higher than those on private plans. One study revealed a 50-percent increase in mortality following cardiac bypass surgery. Another revealed that Medicaid heart attack patients get fewer proven interventions. And these studies represent only the treatment failures. They do not begin to address wellness and prevention shortcomings.

It is not as though we do not have examples of successful models to provide better care and lower costs. For example, Northern Virginia's CareFirst plan by Anthem, CEO Chet Burrell, with his team, is making a real difference. They stratified their patients and found that 20 percent of the population accounted for 71 percent of the costs.

They hired regional care coordinators, local nurse coordinators to work with primary care physicians to focus on the most ill. They have not seen only better care, but also lower costs.

Another example was the subject of a *New Yorker Magazine* article back in January entitled "The Hot Spotters." It is about a primary care doctor, Dr. Jeffrey Brenner in Camden, NJ. He found that 1 percent of their patients accounted for 30 percent of the costs. And, after focusing on the 36 super-utilizers, they reduced hospital bills by 56 percent.

Another model, the patient-centered medical home being piloted across the country, is proving to give better care and, in some cases, realizing savings up to 20 percent.

As these examples illustrate, there are some proven models, but States currently do not have the flexibility to prioritize their limited dollars, because patient challenges vary as broadly as the hollows of Appalachia differ from inner city New York. A top-down, 1-size-fits-all management from Washington will not work.

However, setting expectations with clear goals, guidelines, and measured results will motivate and inspire leaders who will rise to meet the variety of challenges.

Governors are close to the challenges and the problems. Give them the freedom to address them, and they will find remarkable and fair solutions.

Welfare to Work, developed under the leadership of Governor Tommy Thompson, Mike Leavitt, and several others, provided a proven model of State innovations, as Congress enacted bipartisan welfare reform with President Clinton.

Medicaid is in dire need of reform. It is bankrupting both States and the Federal Government, while failing patients. I recommend eliminating the restrictive mandates, such as the maintenance of effort requirements, and granting the States the freedom to be creative and implement what works.

More broadly, Washington should establish, again, clear goals, guidelines, and defined budgets, and then empower the 50 States to become sites of innovation across the Nation. You will be providing the most vulnerable a much better health care system and the American people a better value.

Thank you for this opportunity.

[The prepared statement of Governor Fletcher appears in the appendix.]

The CHAIRMAN. Thank you, Governor.

Next, the honorable Bruce Vladeck. Bruce?

STATEMENT OF HON. BRUCE VLADECK, Ph.D., SENIOR ADVISOR, NEXERA, INC., AND FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, NEW YORK, NY

Dr. VLADECK. Good morning. Thank you very much, Mr. Chairman, Senator Hatch, members of the committee. It is a great honor and a pleasure to be before you this morning.

It has been 14 or 15 years since the last time I sat at this table, in a very different role, of course, at that time, but I must confess to a very strong sense of déjà vu.

In 1996 and 1997 and then in 1998 and 1999, when Senator Rockefeller and I served on the national bipartisan Commission on the Future of Medicare, there was a so-called crisis in Medicare that was considered central to any plan to reduce the Federal budget deficit.

The hospital trust fund was facing looming insolvency. The projected growth rate in Medicare expenditures was forecast to crowd out other discretionary expenditures and make deficit reduction unattainable. The growth in Medicare expenditures was widely characterized in those days as unsustainable.

Now, permit me to remind you what happened then in the Balanced Budget Act of 1997, as has occurred periodically throughout the history of the Social Security Act, since 1938—3 years after its enactment. By 1999, the Federal budget was in surplus.

The expected life of the hospital insurance trust fund was extended by 12 years. In calendar year 1998, Medicare outlays were actually lower than they were the previous year.

There is no reason we cannot do that again. Again, these cycles of change in provisions of the Social Security Act have characterized its entire history.

We do have long-term financial problems with the Medicare program. They must be addressed. But I would suggest to you that the current so-called crisis is, in fact, an artifact of broader problems with the way the Federal budget has been managed over the last decade and with budgetary politics, and it should not be used as an excuse to dismantle one of the most important things the Federal Government has done, or to reverse some of the most promising changes in health policy and health care delivery that have taken place during my career.

In deference to the time, three points very quickly. The first is to remind you what you all know, but us health policy people tend to overlook all the time. When the Balanced Budget Act was first enacted, the Congressional Budget Office estimated that it had moved the insolvency date of the hospital insurance trust fund by 10 years from 1998 to 2008. But by 2001, the estimated exhaustion date for the fund had been moved outward another 21 years to 2029.

There were no changes of any significance in Medicare policy between those consecutive CBO estimates. What happened was CBO corrected its terrible misestimation of the BBA itself, but much more importantly, the economy as a whole grew much faster than anyone had projected.

When you talk about the proportion that Medicare and Medicaid account for in the gross domestic product, there are two parts of that formula. One is entitlement expenditures and the other is the size of the GDP.

The most important thing we can do to solve the so-called entitlement crisis is to get the economy growing again.

Now, I know there are differences about how to go about doing that, but the fact is you cannot separate out the long-term financial health of any of these programs from the long-term financial health of the economy as a whole.

Second, there are a number of other things that have not changed since 1997, but a few have and need to be noted. First, out-of-pocket costs for Medicare beneficiaries have soared, largely because of soaring premiums. The proportion of working people with employer-guaranteed retirement health benefits has fallen and will essentially disappear in the next few years.

We added a prescription drug benefit that is more expensive than it needs to be, without a financing mechanism. We have not made much progress in controlling overall health care costs, and we have enacted the Affordable Care Act.

What this leads me to is to just remind you that, first, even with the addition of the prescription drug benefit and expanded coverage for certain preventive services, the Medicare benefit package is now wholly inadequate. Medicare beneficiaries now have a package of benefits that would not qualify under the bronze standard for privately insured people in the Affordable Care Act. On average, Medicare still pays less than half the total health care costs of its beneficiaries.

Second, as a result, Medicare beneficiaries, as a proportion of income, already spend 3 times as much on out-of-pocket health care expenses than people of working age.

Third, there are still very significant opportunities, which I would be happy to discuss—they are in my statement—to reduce Medicare outlays.

As the chairman said, we have essentially two choices. If Medicare beneficiaries—if older and disabled people—are going to continue to get the medical care they need, we can cap the Federal Government's liabilities through something like the House-enacted budget resolution or a somewhat more refined, genteel version of premium support and shift excess cost growth onto beneficiaries, or we can control the rate of growth of health care costs.

The Affordable Care Act contains many important tools for cost containment. Not all of them will work. We do not have to bat 1,000 on them in order to get a handle on health care costs. If we hit 250 or 300, we will make major progress.

But the only alternative we have, quite frankly, is to reduce coverage for people who can least afford it, which we know will cut off access to health care for many people who need it, lead to worse health outcomes and to the impoverishment of the next generation of beneficiaries.

I am over my time already, and am happy to answer any questions. I thank you very much again for the opportunity to be here.

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

The CHAIRMAN. Thank you, Dr. Vladeck, very much. Finally, Dr. Holtz-Eakin?

STATEMENT OF DOUGLAS HOLTZ-EAKIN, Ph.D., PRESIDENT, AMERICAN ACTION FORUM, AND FORMER DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. HOLTZ-EAKIN. Thank you, Mr. Chairman, Ranking Member Hatch, and members of the committee. It is a privilege to be here to talk about the future of the entitlement programs.

I think, in looking at that future, the one thing we know to be true is that it cannot be the status quo. The status quo for Social Security, Medicare, and Medicaid, the Affordable Care Act, is deeply broken. In many cases, beneficiaries are not served well now and will be increasingly served more poorly in the future.

In all cases, these programs are bleeding red ink and exploding the Federal debt, and the explosion of Federal debt literally threatens this economy, its growth, jobs, and the prosperity of the future. It is, in fact, as Erskine Bowles, the co-chairman of the President's Commission on Fiscal Reform, said, the most predictable crisis in history, and one we have an obligation to avoid.

Medicare, in particular, threatens the budget. In my written testimony, I run through some of the numbers. If you look at it in isolation, it is running a cash-flow deficit of \$280 billion in 2010. By 2020, it is going to run a cash-flow deficit of \$600 billion. It is a program that is just feeding the need to borrow and run up the Federal debt.

We did a rough calculation that suggests that, since 1996, it is responsible for almost a quarter of the Federal debt in the hands

of the public and that, going forward, it could be held responsible for as much as 35 percent of the Federal debt by 2020. It is a prime contributor to the crisis that will envelop this country unless we change course.

It is also failing to meet the needs of beneficiaries, in part, due to mechanisms that have provider cuts, like the SGR. We have physicians now reporting that 67 percent of practices are contemplating not taking new Medicare beneficiaries. And there are other indicators of diminishing access to quality care within the program.

The new cuts under the Affordable Care Act, if we take the word of the CMS actuary, may endanger as much as 70,000 hospital beds and 14 million emergency room visits. These are not indicators of a program that will both survive and serve the future seniors of America well. So we need to change course.

Instead, with the adoption of the Independent Payment Advisory Board, the IPAB, we have taken a dramatic step in the wrong direction that will likely have an increased reliance on these kinds of provider and reimbursement cuts.

The mechanism built into that which requires them to make cuts, on a 1-year basis, that are easily seen and scoreable, is a recipe for sharp provider cuts going forward and diminished access for seniors. It will become the primary instrument for rationing care for seniors in America.

It will likely stifle innovation, because the target for a cut is going to be the new treatments that are often the most expensive, before they have been ironed out and diffused across the health care sector. And, if you are developing a new therapy, if you are developing a new biopharmaceutical, and you have an IPAB that could, at a moment somewhere in the future, cut the revenue stream associated with that, you will be far less likely to undertake the kind of R&D that we need.

So I think this is the worst aspect of the new Affordable Care Act and something that deserves repeal immediately. It is worse than the SGR because it is not subject to the same checks. It is not an institution that is elected. It is not subject to any control by the Secretary of HHS, and it is not subject to administrative or judicial review, and the Congress has limited ability to control it.

The only thing it can do is get a three-fifths majority in this body and then do something that looks roughly the same on roughly the same timetable. It strikes me as not a step in the right direction, but actually a continued diminishment of the quality of the program.

Instead, we need to change course and undertake real reforms, and, in doing that, there will be spirited debates and some disagreement, I am sure. But there are two things that really cannot happen. We cannot grow our way out of this problem, and appeals for economic growth simply, while desirable, are not ever going to be enough to solve the problems. We cannot grow fast enough to keep up with the pace of 7 and 8 percent a year at which Medicare and Medicaid have been growing.

And we cannot tax our way out of this problem. Any attempt to tax our way out of this problem—I think yesterday's CBO report made very clear that would literally drive this economy under.

So we need to reform these spending programs so that they do not grow so rapidly and do not endanger the beneficiaries and the economy. And to do that, I think you need three basic rules to follow. And, while not everyone may like the House budget solution, it did some things. It put the health care programs on a budget. Premium support provides taxpayers with a known liability.

Importantly, it provides the provider community with a known set of resources, and they had better use them wisely, compete heavily for those resources, and serve their clients well.

The same is true in Medicaid. It caps taxpayer liability and allows the States the flexibility to use those resources wisely. We cannot have open-ended commitments and expect these programs not to cost too much.

Second is, you have to foster choice and innovation at every stage. There is no substitute for the kinds of incentives and the kinds of market forces that have served the other 80 percent of the American economy so well over time. Leaving them out of health care is a fundamental policy error.

Third, I think decentralizing at every opportunity, especially Medicaid, is something to keep on your radar screen. We have a vast difference across the States in the size of Medicaid populations, in the size of the uninsurance problem, in literally the cost problems in health care. And to attempt a 1-size-fits-all solution that is drawn up in this city is a mistake, and decentralization will serve beneficiaries well and will serve the States and ultimately the country well.

I appreciate the chance to be here today, and I look forward to answering your questions.

[The prepared statement of Dr. Holtz-Eakin appears in the appendix.]

The CHAIRMAN. Thank you all very much.

The basic question that this hearing attempts to focus on is the role of health care in getting our budget deficits reduced, and I laid out two options. One is to try to control costs, essentially through the Health Care Act, but there are lots of ways to control costs, and the other is to put cost control back onto beneficiaries, as the Ryan budget does.

Health care reform is here. It has passed. The law is enacted. It is not going to be repealed, and we all know that.

We have improved upon it at section 1099, for example, repealing that portion, as it was proper. But it is here. And we all know that we spend about 60 percent more per person on health care than the next most expensive country, and we all know the data, we all know the problems. They are exploding budgets—private, family, public budgets, et cetera—and we have to find a solution here.

Usually, solutions of this magnitude are shared solutions. That is where everyone contributes. When we enacted health care reform, it was based on that premise that we are all going to contribute. Nothing is off the table. We are all going to work together to figure out some way to get an American solution here.

Other countries have their own solutions. We have to find our uniquely American solution, and that was the attempt of health care reform.

So my real question of you—I do not have a lot of time—is, where is the balance here? Where do we find the shared solutions here?

The Act attempts to reduce the rate of growth of health care costs. It is not perfect. Social Security was not perfect when it was enacted. Neither was Medicare. We improved upon it over the years.

Governor Patrick, you and your State have really led health care reform. It has had very good results.

I would just ask you, how do we find the balance here to get health care costs under control? We have to go forward here. There is a temptation here to always talk about the problems. There is a temptation to kind of blame somebody else.

But I am asking the four of you to not indulge in either of those, not to blame, but to try to work to help us understand where we share, because this really is an American problem. We need an American solution.

I will start with you, Governor Patrick.

Governor PATRICK. Mr. Chairman, I want to agree with the premise of your statement; that is, that a blended approach is the right approach, meaning a combination of reforms in the program.

I think in that sense, in that spirit, we all seem to agree, in addition to revenue being on the table, and economic growth, which, by the way, is addressed, we have found at home, by dealing with the broader issue of health care premium inflation.

This is an issue that goes beyond Medicaid and Medicare. Seventy-five percent, 85 percent of the businesses in our commonwealth are small: 10 people, 50 or fewer. They see their commercial activity picking up, and then they get that premium increase for 25 or 30 percent increases, and they say, “You know what? I cannot add that one or two people.”

Well, if they cannot add that one or two people, we do not get an economic recovery. It is really as straightforward as that.

So we have gone at the broader issue of cost containment. That is, for us, chapter 2 in health care reform and moving away from fee-for-service to more integrated payment systems that provide, in fact, better care, but also more cost-effective care, is a big part of that strategy. And I can get into more detail, if you like. I do not want to take all the time.

The CHAIRMAN. Sure. Governor?

Governor FLETCHER. Yes, thank you. I certainly think we share an interest in making sure that we can take better care of the patients that are in whatever program they are in.

One of the things that is very important to realize—and I think Governor Patrick has already mentioned some of the innovative things that they are doing—is that there are some solutions out there.

I may say something that sounds a bit radical, but there is no reason for a patient currently, a young individual, as they are going forward, very few reasons to have a heart attack or a stroke in the future with what we know in health care.

If wellness and prevention and intervention are taken seriously, then we can prevent those things. Look at the costs that would prevent.

What I think is a way of approaching it is providing the guidelines from here, rather than prescribing everything specifically; to set up goals, establish guidelines, and, obviously, budgetary limitations that fit within what you are capable of doing and allow folks like the Governor next to me and the other Governors to be very creative in what they are doing.

You have accountable care organizations within your bill. There are a number of folks around the country who have shown that they can do that. However, even with the regulation promulgation that we have currently, even those institutions—Mayo, Geisinger, Advocate, some others—look at those and say they are not workable, I believe, because they do not provide the right incentives, the right guidelines.

But if those are instituted, and people begin to establish the programs that are proven, I think we can really improve the health and—

The CHAIRMAN. I appreciate that. My time has expired, but when I come back, I am going to keep pressing on this point. That is, where is the sharing here and, second, where do you agree, not where do you disagree, where do you agree on ways to get health care costs under control and to contribute to lowering the budget deficit.

Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman. And we appreciate all four of you taking time to be with us to help us to work through some of these issues.

Let me start with you, Dr. Vladeck. I appreciate your service in the past.

CBO, in its most recent long-term budget outlook, released just yesterday, finds the debt held by the public will exceed 100 percent of GDP by 2021. That is only 10 short years from today.

CBO concludes, “The explosive path of Federal debt underscores the need for large and rapid policy changes to put the Nation on a sustainable fiscal course.”

Now, this summer, credit agencies have issued warnings about our level of debt and urged us to take swift action to right our fiscal ship or risk losing our strong credit standing in the world.

And even your former boss, President Clinton, voicing his concern that Democrats would do nothing to address Medicare insolvency, said, “I completely disagree with that. We have to deal with these things. You cannot have health care devour the economy.”

Now, with these facts for context, I am shocked and, frankly, bewildered that, in your mind, this is not a crisis, or at least the way I read your statement.

Can you tell us what a budget crisis looks like to you?

And then, Dr. Eakin, I would like you to give your impression on it, too.

Dr. VLADECK. Senator, there is no question, in my mind, that there is a budget crisis. I do not think it is a Medicare crisis. I think the major source of our budget crisis—to illustrate further why I make a professional choice not to spend most of my time in Washington—the major source for our budget crisis is we are having a revenue crisis.

Federal revenues as a proportion of the gross domestic product are at their lowest level since prior to the beginning of the Korean War. We had a balanced Federal budget in 1999 and 2000, with Federal revenues at 19 or 20 percent of the GDP and a growing economy, and now we have a stagnant economy and Federal revenues at less than 15 percent of the GDP. No wonder we have a budget crisis.

The second point I would make is that, one can achieve long-term solvency in the Medicare program with decisions much less drastic than are being proposed, again, for example, in the House budget resolution.

The question really that we have to address, the choice—to paraphrase the chairman's opening remarks about the long-term financing of these programs and the long-term financing of a stable Federal budget and a growing national economy—the choice we have to make is whether we are prepared to pay for the commitments we have undertaken over the last 50 years not only to working people and retirees and disabled people, but also our international commitments, or whether we are going to determine that we are not going to pay for them, and that is, to my mind, the source of the very real crisis we now have in the Federal budget and the nature of the choice that the chairman laid out in his opening remarks.

Senator HATCH. Dr. Holtz-Eakin?

Dr. HOLTZ-EAKIN. I fundamentally disagree. The crisis is not that we have a \$1.6-trillion deficit right now and revenues as a fraction of GDP down at 50-year lows. Those are all true facts.

The crisis is that, in either the CBO projections or the administration's budget—take your pick; take the administration's—in 2021 revenues are back up to 19.5 percent of GDP, but the deficit has fallen only to \$1.2 trillion.

This is not a revenue problem. In all of these projections, revenues go above historic norms, and we still have an exploding debt spiral. So that is just not our problem. It is the spending and the growth of the spending fundamentally, and Medicare is part and parcel of that.

And I would encourage the committee not to be seduced by analogies to the 1990s. This is not the late 1990s. There is no prospect of a peace dividend from the fall of the Soviet Union. That was an important part of our budgetary improvement back then.

There is little chance that we are going to get a cessation of health care cost growth, which we got there, and it helped a lot. We certainly do not want to rely on a tech bubble to bring in the revenues as we had in the late 1990s. We paid for it with a big recession early in the 21st century.

And most importantly, we came into the 1990s with a debt-to-GDP ratio that was about 40 percent—it is now almost 70 percent—and the baby boomers were 15 years away from retirement. This is not the 1990s. You cannot run that playbook.

We need deep and fundamental changes to these programs to serve the beneficiaries well and to serve the country well.

Senator HATCH. Thank you. My time is up, Mr. Chairman.

The CHAIRMAN. Thank you.

Next, Senator Bingaman.

Senator BINGAMAN. Thank you all for being here. Let me ask first about a concrete proposal that would help deal with the cost of Medicare. This is a proposal Senator Rockefeller introduced last week that I cosponsored with him and with, I think, Senator Stabenow, maybe some others, to require that Medicaid drug rebates apply to low-income Medicare beneficiaries, dual-eligibles, so-called dual-eligibles, and low-income subsidy-eligible beneficiaries.

I think the estimate there is that that would save something in excess of, I think, \$112 billion over 10 years. And I would be interested, Dr. Vladeck, if you have a view on the merits of this proposal—Governor Patrick, any of the rest of you.

Dr. VLADECK. Senator, I think it is an excellent proposal. In my testimony, I noted that there are a lot of areas in which Medicare is paying too much for what it purchases on behalf of its beneficiaries, and prescription drugs are probably the single most dramatic example of that.

So it is remarkable to me that the Federal Government should have chosen to have the Medicare program, with all the concerns about its long-term fiscal well-being and fiscal liability, and with the very substantial out-of-pocket costs associated with Part D, should have chosen, as a matter of policy, to pay substantially more for the same drugs than the Medicaid program does.

And this would remedy that failure and, in doing so, would save a very, very significant amount of money. So I think, frankly, to me, it is sort of a no-brainer, and we should have done it years ago. I congratulate you for supporting it.

Senator BINGAMAN. Governor Patrick, have you focused on this proposed legislation by Senator Rockefeller?

Governor PATRICK. Not with that care. I am generally familiar with it, and I concur with Dr. Vladeck.

Senator BINGAMAN. Let me ask Governor Patrick another question. I am very worried about this idea that we would block-grant Medicaid.

In my State of New Mexico, we have a lot of people dependent upon Medicaid. Of course, under the Affordable Care Act, we are going to have even more dependent upon Medicaid, and the State depends very heavily upon the Federal Government picking up a significant portion of that cost.

I guess I would be interested in just knowing what kinds of actions you think block-granting of Medicaid would cause States to undertake, your State, as an example, or my State, as an example.

Governor PATRICK. Well, Senator Bingaman, there is one example of a block grant out there which I think every Governor says is a fabulous one, and that is Rhode Island. I do not know if you are familiar with that.

Senator BINGAMAN. I am not.

Governor PATRICK. Rhode Island has a block grant where the block grant is, I do not know, 10 or 15 percent more than the best estimates of what Rhode Island thinks it would ever spend.

If that was done for every State, we would all say, go ahead and block-grant. It would not save you a dime, not a dime. It would cost you more.

What we are dealing with with a block grant, by all the projections—and I can tell you what the impact is in Massachusetts: it is about a \$23-billion cost to us in that cost-shifting over 10 years.

A State with a strong balance sheet like ours cannot absorb that and provide the same level of benefits. So you make a decision. You cut benefits or you cut people, and that brings us back, I believe, to the fundamental question. What is it we are about?

If we are about keeping our commitments to poor people and people with disabilities, vulnerable people, then the partnership that we have had with the Federal Government works.

And there are ways through existing flexibilities and new ones that we have under the Affordable Care Act to squeeze those costs out. But that bigger issue is—and dual-eligibles are just one example; PACE, the special needs plans that some of the other States are using, there are a host of examples, frankly—there are just not enough of them.

There are not enough States using the flexibilities that are in existing law to try to get those costs down.

I just want to return to the larger point. The rate of premium increases, health care premium increases, across the country is a serious problem. It goes beyond Medicaid and Medicare. And we are trying in Massachusetts to deal with that issue, and it would be great to have the help of the Congress in dealing with that issue, as well.

Senator BINGAMAN. My time is up, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Governor Patrick, your testimony zeroes in on the need for flexibility in Medicaid. The Affordable Care Act allows the States to have that flexibility in 2017.

Now, there is bipartisan legislation here in the Senate to move that date up to 2014, and the President has endorsed that legislation.

Do you agree with the President on this?

Governor PATRICK. I am fine with that, Senator. I know that you are the coauthor of that legislation. I would say that even if you were not asking me the question.

Senator WYDEN. Very good.

Governor PATRICK. I will tell you, honestly, Senator, I do not foresee our availing ourselves of a so-called waiver because we are so far down the path now, we are in pretty good shape to comply with the Affordable Care Act.

Senator WYDEN. The second question I want to ask you, Governor Patrick, is about this question of the early retirees going on Medicaid.

Governor PATRICK. Right. That is the bit that was in the news recently.

Senator WYDEN. Correct. And I have tried to assess your program, because it seems to me it tracks philosophically with where I have been, which is to expand coverage by creating private sector choice and kind of a marketplace.

Governor PATRICK. Right.

Senator WYDEN. And what it seems to me you are doing without a subsidy is putting those folks in Commonwealth Choice. So they are making, say, \$64,000, no subsidy, and they get to go to Commonwealth Choice, and it seems to be working, no subsidy, and looks like a pretty appealing way to use the private sector to expand coverage.

I assume you want to make sure that you can keep that, right?

Governor PATRICK. Well, that is right, yes, and your question asked for a yes or no answer, but—

Senator WYDEN. Perfect.

Governor PATRICK [continuing]. Can I expand just a little bit?

Senator WYDEN. Sure.

Governor PATRICK. I think that for us, what we have is, as you acknowledged, a hybrid public-private solution, and we have a range of public applications or subsidies, depending on the level of income and the ability of people to contribute.

But the working theory has been that getting people insured, giving them access to preventive care, some of the wellness points that others have made, actually brings total system costs down over time.

The next chapter is to make sure that those cost savings are passed on in the form of low premiums.

Senator WYDEN. I think your answer is a thoughtful one. I just wanted to make sure that folks knew that people were trying to be innovative, were using the private sector without a subsidy. We were able to expand coverage, and, certainly, early retirees are very deserving, and I commend you for everything that I have heard.

Governor PATRICK. Thank you.

Senator WYDEN. One question for you, Dr. Vladeck, because of your experience. And I think he has left, but you may be aware that Senator Grassley and I have introduced a bipartisan bill to open up the Medicare database and make it possible for people all over this country to really get a sense of some of the kind of key information that can help us make better choices in terms of both quality and cost containment.

I am sure you have not had a chance to look at all the details. But conceptually, based on what you went through at HCFA, would you be in support of what Senator Grassley and I are talking about?

Dr. VLADECK. Senator, I will confess to a mild conflict of interest. My brother was one of the lawyers who lost the original suit with the AMA on the Freedom of Information Act request for that data.

The prohibition on the sharing of that data is about as egregious as a special interest exception to the Freedom of Information Act as exists anywhere, and I would certainly enthusiastically support its alteration by statute.

Senator WYDEN. Very good. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Carper?

Senator CARPER. Thanks, Mr. Chairman.

To our guests, welcome. Recovering Governor, I especially welcome you here today.

I think there is at least one area that we can agree on with respect to Medicare and Medicaid. According to Federal estimates, more than \$70 billion is lost each year to waste and fraud from those two programs. In Medicare alone, there is about another \$50 billion in improper payments reported by GAO, which is mostly over-payments, and the administration has promised to cut that number in half.

But the bad news is that there are a lot of folks with criminal intent who want to steal money out of the Medicare trust funds and from States and the Federal Government through Medicaid.

The good news is that Tom Coburn and I and a bunch of our colleagues, Democratic and Republican, just introduced yesterday legislation that attempts to go take the next step in going after some of those funds.

I look at the Federal Government, and sometimes people I talk to at home and around the country believe we operate under what I call a culture of spendthrift, and they would like to see us adopt a culture of thrift. And what I would like to say is, we need to look in every nook and cranny of the Federal Government, including entitlement programs, including Medicaid and Medicare, to make sure that we are getting the best result that we can for the money.

My bumper sticker these days is "better result for less money," and for health care, better health care results for less money or at least for not a whole lot more money.

About 2 months ago, among the witnesses we had before us was a fellow named Alan Blinder, who now teaches up at Harvard and used to be vice chairman of the Federal Reserve, and he was saying to us how health care is the 800-pound gorilla in the room. If we do not do something about health care costs, we are doomed in terms of deficit reduction, and, frankly, in our ability to compete as a Nation against the rest of the world.

And I said to him, when I had Q&A, I said, "Well, Dr. Blinder, what should we do about these health care costs?" And he said, "I am not an expert on this stuff, but my advice to you would be to just do as you said, find out what works, and do more of that."

Find out what works, and do more of that. So I think one of the things that works is going after waste and fraud. There is a number, I would mention maybe a half-dozen or so provisions in our legislation, and I would ask for the Governor and former Governor, the recovering Governor out here, to get into some thoughts about what the States are trying to do on the waste and fraud side that we can learn from you.

But among the provisions in our legislation, there are about 15 or so, maybe 20, that actually are pretty good ideas that enable us to do a better job at going after wasteful and fraudulent spending.

But among the provisions, one is to enact stronger penalties for Medicaid fraud, and another is to establish stronger fraud and waste prevention strategies. Among those, we have in both Medicare and Medicaid this policy of pay-and-chase—pay-and-chase. We pay the money, then we go out and try to recover it, sometimes 2, 3 years after the fact, and it is just impossible, almost impossible to do.

So we are going to try to get off of pay-and-chase and take a stronger proactive approach. We want to curb the theft of physician

identities. We have too many physicians, dead physicians who are prescribing. It could be equipment, it could be medicines and that sort of thing, in some cases, for people who do not live and some of the prescriptions are going for controlled substances. All too often, they are going to people who simply use that money to feed the drug trade, and we end up spending money for that, spending taxpayer money for that.

We have a bunch of ideas on deploying some cost-cutting technologies to better identify and to prevent fraud.

My question to Governor Patrick: I was just in your State last weekend to visit my son, Christopher, and I had a chance to revisit where Christopher had gone to school, and it was really nice. We had a beautiful weekend.

Governor Fletcher, my sister is one of your—I asked you if you knew my sister Sheila, and you said, “I know several Sheilas. I do not know if one of them is your sister.” She is out there in Winchester.

But give us some thoughts on what the States are doing, maybe in Massachusetts and Kentucky, what the States are doing, successful anti-waste and fraud efforts that you might share with us. Think of the States as laboratories of democracy.

Governor PATRICK. Well, first of all, Senator, let me thank you and congratulate you and your colleagues on the bill you proposed and the elements you described. The pay-and-chase is the classic way of recovering Medicare and Medicaid fraud.

Our attorney general, who is an independent constitutional officer, has ramped up her own recovery initiatives, and we, through the budget, have supported her efforts with some additional resources to do that, and she is getting pretty good results.

But you are right. There is a lag of a couple of years while that money has been out and paid out before it is recovered.

I think that this question of dual-eligibles is a great big low-hanging fruit, and I think most people agree with that. It is 40 percent of the spending in the Medicaid budget right now, because we have two different agencies with two different sets of regulations dealing with the same person, and sometimes those regulations are in conflict.

I am sure that Dr. Vladeck and Dr. Holtz-Eakin could give some more specific examples of that. But we are trying to unpeel all that, and, frankly, the Affordable Care Act has given us some tools we did not have before. We can get right at that.

Senator CARPER. That is the idea. Good.

Governor Fletcher?

Governor FLETCHER. Obviously, it is very important. When I first took office, Kentucky was proud of the fact that their administrative cost percentages were very low, which meant all they did was process and pay claims.

What we have begun to do is invest a lot more in administrative aspects to start evaluating the claims. Then we started looking—and you can see patterns when you start looking at treatment patterns, prescribing patterns of physicians.

We hired nurses, we hired doctors to review cases. And when you see waste, fraud, and abuse, usually you will see someone, in order to make it profitable to them, they are churning a lot of people

through, and when you examine data, you can start looking at that and going after it.

The other thing I think is important is, we are paying based on treating illness. It may be an odd way of going after waste, fraud, and abuse, but, if you pay for outcomes, you cannot fraudulently produce outcomes. And so I think as we shift—and certainly I agree with that aspect of the legislation to start looking and paying for outcomes, and that is what I was referring to, setting goals and guidelines. If we start doing that, that will reduce waste, fraud, and abuse.

The other way we considered and looked at—and I am not sure currently what they are doing in Kentucky regarding this—but insurance companies have panels of physicians who are credentialed. They avoid waste, fraud, and abuse by making sure that the physicians who are providing their preferred coverage are those who have gone through certain requirements and credentialing.

If we partnered in a public-private partnership with them, I think we could probably utilize a lot of the data they have and make sure that the physicians whom we are using are truly doing what they need to do.

Senator CARPER. All right. Thank you very much for those thoughtful responses.

The CHAIRMAN. Thank you, Senator.

Next, Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

It is my own view that one should never have a hearing of this sort, let us say, on Medicaid and Medicare and cutting their costs, without saying entirely fairly that that has to be accompanied by increases in revenues, cuts in defense budgets, things of this sort.

In other words, we have a habit in the Congress of saying, "Well, we are going to cut this, we are going to cut that," without taking the larger view, what could make it maybe less possible for us to cut so much.

Secondly, I would like to say to you, Dr. Holtz-Eakin, that you used the word "rationing" in terms of Medicare, the Independent Payment Advisory Board—which was a Republican idea and was passed in the late 1990s by the Congress, it was a Republican idea—what it does, I think, is the largest of all the cost savers, and that is, it aims at not having a fee-for-service business.

The system now is that people come up here, they work the Congress like crazy, lobbyists making millions of dollars, they each pick on somebody whom they have a special relationship with, whether it is durable medical equipment or anesthesiology or anything else, they work the Congress.

The Congress often does not know how to say no, and the Congress has a practice of never saying no, and so costs go up. And that is one of the reasons that you really do not want to have Congress make those decisions, therefore, on how reimbursement patterns work.

You want to have the Gail Wilenskys and the Stuart Altmans and the Bruce Vladecks, et cetera, people who have broad health care policy experience, making those decisions.

The Congress does not like it at all, and that is very obvious, because they do not get to do the big connection with the lobbyists and all the rest of it.

But the fee-for-service system is what drives up costs. You present your fee for the service which you have done; it is automatically paid for. How are you going to keep costs down on a system like that?

So you have to go for this accountability, and that is what the Independent Payment Advisory Board is really going to look to, and we will save over \$500 million dollars over the next 15 or 20 years on Medicare costs.

But in the law, it says you cannot reduce benefits at all nor can you increase copayments. So it is not the patient, the Medicare patient who gets hurt. It is the system which has to adjust and, therefore, they have to look at accountability—how good is it, how would it compare to 3 years ago, what about MRSA or bathrooms being cleaned?

Everybody has to participate, and what you say, this is not the 1990s, it is the next decade or two, I agree with you. So we have to change the way we think. Others were talking about how premium increases are going up so fast. Well, the public option did not work, so we tried something called a medical loss ratio. The medical loss ratio takes effect in 2012, and that says you have to spend 85 percent of all—you can increase your premium all you want, but you have to spend 85 percent of it on health care results, health care that actually makes people better.

To wit, if that had been in effect since 2010, it now being almost 2012, there would have been rebates, because that is part of the law—if they do not spend it on health care, they have to rebate—they would have had to rebate already billions of dollars in the 2 years that it has not been in effect. So there are lots of ways of doing that.

I also wanted to say to Governor Patrick that I very much appreciate and identify with who you are and what you say. I am a very, very passionate advocate of Medicaid recipients, and that is a hard thing to find around here, because they do not have lobbyists, they do not vote, they do not contribute, and people do not know much about them.

But people think it is only for poor people. Well, that is enough reason to have it. You have to have a safety net. That is what America is. You have to protect poor children, you have to protect poor families. It is not their fault, in most cases.

So the concept of doing this is not just to protect the poor, but also to protect the middle class, and I want you to talk about that a little bit from your experience in Massachusetts.

In other words, it is moms and dads as they get older, it is disabled children. There are a lot of people who are sitting in wheelchairs, as you often see in groups out in the halls, and they are being protected by something called Medicaid, but we are so quick to sort of get rid of it. Not talk about revenues, not talk about other things, but just talk about, “Oh, we are going to get rid of Medicaid,” which is the third-largest program in the Federal Government other than Social Security and the Department of Defense.

How does it affect middle-income folks?

The CHAIRMAN. Very briefly, because the time is expiring.

Governor PATRICK. Sorry, Mr. Chairman. Thank you, Senator Rockefeller.

Probably the biggest way in which Medicaid at home cuts across all income groups involves people with disabilities who utterly rely on Medicaid and are frequently in that dual-eligibles case, in the case of those over 65.

Senator ROCKEFELLER. Nine million people.

Governor PATRICK. Exactly, and a whole lot of costs that can be captured.

Senator ROCKEFELLER. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Next, Senator Nelson?

Senator Burr, I am sorry. Way out there in left field—or right field. [Laughter.]

Senator BURR. I am easily forgotten. Thank you, Mr. Chairman.

The CHAIRMAN. You are solidly recognized.

Senator BURR. Governors, welcome. Bruce, great to see you; Doug, as always.

And I have to admit, Governor Patrick, I was somewhat amazed, because most Governors come up here and they have a laundry list of changes they would like to see to health care plans. Yours was not a laundry list.

So it compelled me to look at the experience that Massachusetts has, and what I found was the Federal participation in Massachusetts for Medicaid went from \$5 billion in 2005 to \$7.5 billion in 2010.

At the same time, the State's share was \$4.9 billion in 2005 and dropped to \$4.7 billion in 2010. I can sort of understand why you are an advocate of it, because the Federal Government continues to pick up a larger and larger share of the health care costs of the Medicaid population.

Bruce, really quickly. Should means-testing become part of the Medicare structure?

Dr. VLADECK. We already means-test, in effect, very significantly on the revenue side of Medicare. To means-test it on the benefits side is both an administrative nightmare and I think is a move away from the fundamental—

Senator BURR. I take that as a “no.”

Dr. VLADECK [continuing]. Social insurance.

Senator BURR. I take that as a “no.” Do you agree that the creation of IPAB and empowering them to make reimbursement decisions was the right move?

Dr. VLADECK. My understanding of the logic of IPAB, Senator, has a lot to do with the way in which the Congressional Budget Office and other budgetary scorekeepers look at the world, and I have real qualms about that.

I am very sympathetic to Senator Rockefeller's points. On the other hand, I am also familiar with the history of the Interstate Commerce Commission and other efforts historically of the Congress to delegate responsibility for setting prices when it felt itself politically unable to do so.

We have, in effect—at the moment, the U.S. Congress is the court of last resort on payment rates under Medicare to, I think, an excessively detailed degree.

This is a very difficult problem in public administration, and I am not sure the IPAB is the right answer, but I am very sympathetic to the notion that the Congress has not distinguished itself particularly in that regard in recent years either.

So I do not know quite what the exact right answer would be.

Senator BURR. And I think the point Dr. Holtz-Eakin was saying was that, if you empower a body to set reimbursements, you have now empowered a body to affect the scope of coverage.

Dr. VLADECK. I do not believe that. If you look at all of the effort both the Congress and CMS devote to changing reimbursement levels, providers always claim if you take a nickel out of their payment rates, people are not going to be able to get service. Ninety-eight percent of the time, those claims turn out to be wildly exaggerated.

I can cite chapter and verse, Senator, in that regard.

Senator BURR. Under Medicare, it is believed that 40 percent of primary care docs will not see a Medicaid beneficiary and that 70 percent of specialists will not see a Medicaid beneficiary.

Does that affect their outcome of care?

Dr. VLADECK. Absolutely. Medicaid patients have great difficulty in access to care, in some communities more than others, and one can only imagine what would happen to those problems in a block grant situation.

That is why CMS has finally, belatedly, issued regulations to begin to figure out how to define, let alone to enforce, the access provisions in the statute, and that is why many of us are so unhappy with the Obama administration's position on the lawsuits to which several members have referred today.

Senator BURR. Is the decision to see Medicaid patients, either by a primary care physician or by a specialist, because of the low reimbursements?

Dr. VLADECK. Absolutely.

Senator BURR. Do you agree that 40 percent of primary care physicians and 70 percent of specialists will not see—

Dr. VLADECK. I am always a little skeptical about those numbers, but in general, that is a very—they correctly define a very real problem.

Senator BURR. The analysis published in the *New England Journal of Medicine* last week underscores how children on Medicaid are having a problem with access when seeking an appointment. Sixty-six percent of those who mentioned Medicaid or CHIP were denied appointments compared to those who said they had private insurance. It is real.

I mean, this is the *New England Journal of Medicine*. I will end, because my time is up, but, Governor Patrick, you said in your testimony, and I quote, "Stick with what works."

I think the whole debate that we are having is does Medicare—does Medicaid, as currently constructed, work? To me, it is appalling that you could have a system where 40 percent of the primary care docs and 70 percent of the specialists say, "I have to tell you,

I am not making enough to see these kids.” That is an injustice to the kids.

It is a flaw in the system. It cannot be something that is working, because all the information tells us it is not. My hope is that we will work aggressively to change it.

I thank the chair.

The CHAIRMAN. Thank you, Senator.

Senator Nelson?

Senator NELSON. Governor Patrick, thank you again for coming to Florida and making your presentation. Thank you very much.

I want to ask Dr. Vladeck, and I am picking up on the chairman’s question here earlier. We are trying to find a solution here, and there is not a lot of agreement in the two sides that have been expressed here, and it is, unfortunately, typical of what is going on around here these days.

But let me propose something, and tell me whether or not you think this would work. When you look through Medicare now on what seniors pay, there is this convoluted difference on different services.

In some cases, you have a deductible; in other cases, you do not. In some cases, you have a co-pay; in other cases, you do not.

What would be the effect if you had a uniform deductible and a uniform co-pay?

Dr. VLADECK. Senator, I think that could be a very helpful thing. That would make life easier for beneficiaries and probably have a healthy effect on constraining the costs of the program.

We ought to address, as part of the same set of arrangements, some limitation or ceiling on total out-of-pocket costs for Medicare beneficiaries, and the critical issue is to do it in a way that does not increase the total costs for beneficiaries or have a disproportionate impact on those who use the most services because they are in the least good health.

But I think one could design a change in the structure of benefits and copayments in the Medicare program that would be budget-neutral in the short term and save the government money over the long term, without increasing the financial risk to beneficiaries, and I think that would be an excellent way to move forward.

Senator NELSON. Tell me what you think—any of you—about our attempts to set up accountable care organizations in the health care bill. Do you think that this is going to work?

Dr. HOLTZ-EAKIN. No.

Senator NELSON. Dr. Holtz-Eakin says no.

Dr. HOLTZ-EAKIN. We have seen the early returns on this already. There is a 400-page rule out there, and the institutions on which it was modeled will not touch it.

Senator NELSON. And it is a proposed rule, and they are getting a lot of feedback from a number of us at this table, and, hopefully, it is going to be refined to be more workable.

Does anybody think that an accountable care organization is going to work?

Governor PATRICK. We do. I do not think it is going to be the sole solution.

Excuse me, Dr. Vladeck. I did not mean to jump ahead of you.

We do not think it is going to be the sole solution, but it is a part of the solution, and there are examples of accountable care organizations today in Massachusetts that are working and have been shown to contain costs.

But it is not enough all on its own. It is just an element of a more comprehensive solution.

Governor FLETCHER. Senators, regardless of philosophy, party affiliation, we have to change the way we pay for health care. Everybody agrees to that.

Whether the current structure of ACOs is going to work—I think there is a lot of question as to whether, obviously, these regulations are going to work at all.

But we are going to have to transition, to begin to pay for integrated delivery of care. Right now, I will tell you, the structure, because of what the current reimbursement system has created out there, is very ill-prepared to accept the degree of risk management and integrated care that the current legislation asks for.

We are going to have to do something. There is a model, eventually we will get there. I doubt that the current approach is going to work, though.

Dr. VLADECK. If I could just second Governor Fletcher's comments. This is one of those issues in which you have to give it time, and you need the willingness of the political system to give things time.

Eventually, ACOs could make a major contribution to improving quality and controlling costs, but most of the delivery system is not yet ready. It is going to take 5 to 10 years just to get the information technology in place, even with all the support under the Recovery Act, that is necessary to effectively manage an accountable care organization.

And I think if we can just figure out, as a matter of policy, how to help organizations make the transition and have institutionally the patience to let that happen, I think there is still very great promise here.

Dr. HOLTZ-EAKIN. Just to be clear, and in the spirit of the chairman's opening question to us, this is something about which all sides agree that there has to be a transformation of the delivery system to have integrated systems and much more care coordination and monitoring and managing of those, the chronic conditions.

I deeply doubt that the approach taken under the Affordable Care Act will deliver that. But that does not mean that is not what we need and that there are not routes to get it.

Senator NELSON. Well, how do you do that? I mean, the whole thing of ACOs plus electronic records is to try to get everybody coordinating with everybody so you do not have the duplication of all the services.

Dr. HOLTZ-EAKIN. We have seen ACO-like entities emerge on business models of their own choosing, with their own ability to pick the providers and develop their own reimbursement systems, and that was a good thing.

This is literally a 1-size-fits-all, put the hospitals in charge disaster. It is not going to work.

I think, in the spirit of the opening question, there is agreement that we need to do a couple of things. Put these programs on budg-

ets. Make the resources scarce and valuable so that people treat them with the accord the taxpayers deserve.

Drive more choices and drive the delivery system to integrate and coordinate better, and one vision of that is in the House budget in premium support, which would require the private sector to drive that innovation.

A second would be to take something that looks like the current setup and put a budget constraint on it. And I at least think if we put a budget constraint on Medicare, allow those both to coexist and let people pick, I will place my bets on that. I know where the fee-for-service system would end up—out of business.

Senator NELSON. Mr. Chairman, I will second what Dr. Holtz-Eakin has said. There is some concern with hospitals organizing ACOs, in which they are buying up doctors' practices and that becomes the ACO, that then you have a monopoly.

Now, you let a bunch of doctors organize an ACO outside of the hospital, then that might be a different thing. And, as we look at these regs, we ought to make sure that, independent of hospitals, they have an opportunity to flourish as an ACO.

The CHAIRMAN. I agree that we should find ways to make them work, moving toward more integrated care. This is extremely complicated stuff, but I think we should not just close our minds, but just bona fide work with them so they can move better toward integrated managed and coordinated care so doctors and providers are focusing more on patients and less on fee-for-service. But I understand the budget parameters. It is a good idea, but let us work to make this thing work.

Senator Grassley?

Senator GRASSLEY. I am going to ask one short question of the Governors, but after I give a background for it. I will only ask for the expertise of the Governors, but I also raise these issues because, when it comes to block-granting or the issue that we are discussing about block-granting Medicaid or the possibility of doing that, there are a lot of tough questions that particularly people on my side of the aisle ought to think about in the process of doing that.

And, of course, the issue is giving more flexibility to the States to do this, with the idea that we might get more for our money. But I think it is quite reasonable that Congress is not just going to hand over hundreds of billions of dollars to the States with no strings attached.

Congress is going to require that the money be spent on health care and that they cannot spend money on roads, highways, and football stadiums. Congress is going to require States to spend the money on low-income individuals rather than higher-income individuals.

So even under a block grant, a State Medicaid program will cover health care services for low-income individuals.

What is unclear to me is what happens to current populations under Medicaid. Currently, States are required to cover children, pregnant women, the elderly, and the disabled. It is unclear what requirement States will be under if there is a Medicaid block grant.

The non-elderly, non-disabled populations can generally be covered through private insurance. The elderly receive their coverage primarily through Medicare.

I am most concerned about the non-elderly disabled, particularly, disabled children.

So my question to the two Governors is, do you think a State should have the flexibility to reduce coverage to the non-elderly disabled or not cover them at all? And by the words "non-elderly disabled," I am talking about most of these people probably being born into disability.

Governor FLETCHER. Senator Grassley, I think your passion for making sure we care for those most vulnerable in our society is shared by, I will say, every Governor regardless of what party.

So I do think providing more flexibility to the individuals who have a similar compassion for people is a good thing to do, and it will bring some good results.

Without strings, I agree with you, you are not going to send money down to the States without having certain requirements, guidelines, and other things.

I think you can establish goals. I think States can be required to even establish their own goals for outcomes.

On disability, clearly, if there are folks of certain levels that you feel need to be cared for, then that requirement can be attached as a string. What you find, though, is that, if you focused care on the most needy, the most ill, you would have the biggest impact on improving the quality of health in populations.

That does mean that you have to look at caring for and focusing most on those who need it the most.

If you had unlimited dollars, you could, obviously, cover everyone, and we would all not be here. But I do think that when you look at covering the most ill, that there are savings that have been proven that can come from that. That can allow you to cover more people in a better fashion.

Senator GRASSLEY. Governor Patrick?

Governor PATRICK. Senator Grassley, thank you for your question and, also, for your sensitivity. And I want to build on what Governor Fletcher has said about the efficacy of focusing on those who are most ill and, also, doing it in integrated ways.

This is back to the question of how we get better care of a higher quality that is more cost-effective. And the ACOs, as we have been trying to develop them in Massachusetts, are along those lines.

I think that the question of flexibility sometimes strikes me, frankly, Senator, when I hear some of my colleagues talk about it, as a bit of a canard, because there is a tremendous amount of flexibility we have been offered and we have utilized, under the Obama administration and the Bush administration, in our own health care reform to try to get at some of these new ways of delivering service and, frankly, also, paying for that service at a—getting better value for fewer dollars.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Cardin, you are next.

Senator CARDIN. Thank you, Mr. Chairman. And let me thank the panelists. Sorry I could not be here for the entire hearing. Secretary Clinton was before the Foreign Relations Committee.

But now back to the domestic realities. I know there has been some exchange in regards to the merits or demerits of block-granting Medicaid.

Governor Fletcher, I understand you mentioned CareFirst. We appreciate the plug for CareFirst, which is based in our State.

Let me just tell you one of the concerns I have. I have been in Congress long enough to know that, whenever we move towards block-granting, it is a code-word for reducing the Federal Government's participation in a program.

In many cases, it is a glide path to the elimination of the Federal Government's participation in a program. We have seen that happen frequently in different areas.

I look at the Medicaid program, I look at its importance in my own State. I look at our community health centers and know that, without the protection that we have currently on the reimbursement levels, which use a prospective payment system that allows for accumulated services to be covered in our community health centers, we would not have that safety net of facilities in Maryland that provide primary care to a large number of very vulnerable people.

Now, I know my State is committed to doing that, but, if the pressures become great on its budget, would it be able to maintain that type of focus?

We all want flexibility, but, if we do not have the structure at the national level to preserve the Medicaid program when tough budget decisions have to be made, will you be able to do this without a Federal partnership that is reliable and provides the resources to continue these basic services?

Governor? Either Governor.

Governor PATRICK. Senator, I want to just be as plain as possible. We are, in Massachusetts, one of only three States with a positive fiscal outlook, according to a host of studies.

The forecasts are that block-granting Medicaid could cost Massachusetts \$23 billion over 10 years. We cannot afford that, not without taking deeper cuts than we already have, thanks to the global economic collapse, in other essential services.

That partnership that we have shared and that you refer to with the Federal Government is how we have been able to deliver health insurance to 98 percent of our residents. And it does not let us off the hook, and we have not viewed it as letting us off the hook to continue to look for ways to get more value for what we spend and how to spend less.

I mentioned earlier it is a very, very important initiative of ours, and of mine in the second term, to get at the broader question of health care costs, which are, I think, a threat to our economic recovery not just in Massachusetts, but in the Nation.

And some of the solutions that we have been talking about here, and on which there seems to be broad consensus, around integrated care and moving away from fee-for-service in favor of paying for outcomes or the quality of care, are ways to go.

The fact is at home, though we have a hybrid solution, a public-private solution, the market has not solved this on its own. The market has required a little nudge from us, a partnership with State Government.

So I want to concur with the premise of your question. The block-granting—well, let me make it more positive.

The partnership with the Federal Government around Medicaid I think is essential to our meeting our commitment to care for the most vulnerable in our population.

Senator CARDIN. Medicaid was intended to give the States the ability to make those types of innovations in health care, to give you the ability to set up delivery systems that could be cost-effective, so that you could gain savings. If there are ways that we need to modify the program to allow that to continue to occur, that is something I think all of us are interested in making sure is maintained.

Our concerns involve eligibility and service level, that, if we do not have Federal parameters there, then the chances of having adequate coverage in the future are questionable.

Governor FLETCHER. Senator, it is good to see you again after serving in the House with you.

Concerns about block grants, obviously, are real, but, if you look at establishing guidelines and even partnerships, as you may refer to them, whether it is community health centers or what have you, I think, again, there are guidelines, structures, outcome goals, those sorts of things that can be established with those.

It kind of reminds me of the couple who were getting married, and the counselor told them, "Now, you can occasionally tell your spouse what to do or you can tell him how to do it, but you can't tell him both." And when you get that proscriptive, you really restrict how innovative the individuals are.

Community health centers, yes, they are good. You need to look at the reimbursement that you are—I mean, it is quite a bit higher than what you are paying other folks, in most cases. They are on the one side, and we have worked with some, actually, we are expanding some of the care in a community health center in Kentucky.

Their reimbursement often is on a cost-plus basis. There are a lot of grants that are available to them. So they receive a lot more money, and I am not sure that the outcomes there are measured and guidelines are given as well as they could be.

So I do not think it means we cannot partner. It is just, give us some flexibility, incentivize innovation.

Senator CARDIN. I need to at least point out on the record that community health centers handle an awful lot of uninsured patients, which helps us keep them out of emergency rooms. They provide a lot of preventive care, an outcome that would not otherwise be covered under their reimbursement levels, and they are a very small part of the Medicaid budget, yet they produce a great deal of savings in our system.

If time remains, sir.

Dr. HOLTZ-EAKIN. If I could just make one point. Your defense of the programs is laudable, and I understand that, but I just want to make the point that, going forward, the Federal Government is

not going to be a reliable partner. Once something changes, it is going to be broke.

Senator CARDIN. Well, if we do not deal with our deficit, we are going to have a serious problem, there is no question about it, but that requires a comprehensive approach, and I think all of us would agree on that.

I think we can do that, and we can bring down health care costs in this country in a way that does not jeopardize the reimbursements that we are currently making for poor, elderly, or disabled Americans.

Dr. HOLTZ-EAKIN. My point is that, if we defend every aspect of the status quo with the same vigor, nothing will change, and we have a big problem.

Senator CARDIN. We are in total agreement there.

The CHAIRMAN. I was reading this morning some news that Majority Leader Cantor has withdrawn from the Vice President's budget negotiations over revenue; that is, he does not want any revenue at all to be included in any budget deficit reduction package, and I am very disappointed over that.

I believe Senator Hatch, someone up here, mentioned Admiral Mullen's statement that the biggest national security threat we have is our huge budget deficits, and I agree with that.

I think revenue is needed for a whole host of reasons. And more importantly, I think leadership is needed. Leadership is needed on both sides of the aisle and at both ends of Pennsylvania Avenue.

We all worked together to get health care reform passed, and we are going to have to work together here to get our budget deficit reduced.

The largest deficit reduction measures in the post-World War II era both had significant revenue increases. About one-half of the total amount of deficit reduction in each bill, each tax increase, reduced deficits by almost \$1 trillion over 10 years, in today's dollars, in the 1993 budget agreements.

Second, you cannot ask folks who receive Federal benefits, whether Federal retirees, Medicare or Medicaid recipients, or farmers, to bear the sacrifice of deficit reduction alone. There has to be fairness and balance in the ultimate deficit reduction agreement. That means revenues must be included so that everyone is participating in addressing a critical national problem.

My recollection is, too, that, in the last 10 years, 1 percent or maybe one tenth of 1 percent of Americans, after tax, had received about a 36–37 percent increase in revenue, disproportionate to the middle-income Americans who, frankly, are not participating at all.

The gap between upper-income Americans and average Americans has been widening. It is not narrowing, it is widening.

Third, I think we can raise revenues and have a positive economic outcome. Revenue increases in the 1990s gave us 23 million new jobs, the longest economic expansion in U.S. history, and a balanced budget.

I have worked to lower taxes. I worked with Chuck Grassley to cut taxes in 2001. I supported that tax cut. We had a \$5-trillion surplus projected back then. But today we are looking at \$10 trillion in additional debt over the next 10 years, and I, therefore, believe that increased revenues have to be part of the solution.

I might also point out, in 1982, President Reagan signed a tax bill increasing revenues by about \$800 billion over 10 years, in today's dollars.

I am disappointed that Leader Cantor has withdrawn. I think he should stay at the table. I think we should keep working, as difficult as it is, and find a balance between Medicare cuts, additional Medicare cuts, so long as there is commensurate additional revenue. We need a balance here.

This is not the end of this matter, clearly. We have to keep working on it. But just in my view, very strongly held, to get that balance, there is going to have to be some revenue.

Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman. And I appreciate you, and I do appreciate the chairman's recent comments.

But let me make this very simple point. Following the passage of the almost \$1-trillion, now over \$1-trillion stimulus, which most will agree was a spectacular failure, our national debt increased by 26 percent.

Now, I do not know what one can do or what I can do to get this message across that we have a spending problem. There is just no question about it.

But having said that, let me just ask this question of our witnesses, both Governors here today.

This fall, the Supreme Court will hear a case called *Maxwell-Jolly v. Independent Living Center of Southern California*, which could have dramatic implications for the States.

The 9th Circuit determined that, "A plaintiff may bring suit under the supremacy clause to enjoin implementation of a State law allegedly preempted by Federal statute regardless of whether the Federal statute at issue confers an express 'right' or a cause of action on the plaintiff."

Now, in effect, the 9th Circuit's decision would have given a private right of action against the States, which might substantially increase Medicaid costs for the States.

In its May filing with the Supreme Court, the Obama administration's Department of Justice took the opposite position from the 9th Circuit, saying that Federal law does not confer a private right to action over the—and the language in the statute is, over the "sufficient to enlist enough providers" provision.

Let me just state that in a different way, because it is a tough question, and I would like to have both of your inputs on this.

This fall, the Supreme Court is going to hear the *Maxwell-Jolly* case on whether the "sufficient to enlist enough providers" provision confers a private right of action in Medicaid.

Now, I am very concerned about this case, because a private right of action would cause a very costly new wave of litigation for the States. Take it from me, as a former trial lawyer.

Governors Patrick and Fletcher, do you agree with the Obama administration's Justice Department that this should not be a private right of action in Medicaid, or do you not agree with it and, if not, why?

We will start with you, Governor. We are old friends, and I appreciate you coming here today.

Governor PATRICK. Thank you. You were talking to me, I hope, Senator.

Senator HATCH. Yes. [Laughter.]

I do not agree with you, but we are good old friends.

Governor PATRICK. Well, we have worked together, and I appreciate that.

Senator HATCH. Yes, we have.

Governor PATRICK. Senator, I know just a little bit about the case. I am not as deeply informed as your question suggests, but I am worried about what I hear. I am worried about the idea of a private right of action around Medicaid rates.

I get the point that Medicaid rates are inadequate. I think, maybe when you were out of the hearing room, Senator Burr was raising the question about the concern, which I share, that in many cases—in some cases—Medicaid recipients are not able to see a specialist because the specialists are not interested in those rates.

I am worried about that, but I am not sure that the problem is going to be solved through a private right of action.

Senator HATCH. All right. I am also friends with Governor Fletcher. So I would like to hear your view.

Governor FLETCHER. I agree with the opinion of the Obama administration's Department of Justice, that I do not think that constitutes a cause of action.

The ramifications of that, the cost to the State, and any Governor knows—a lawsuit is handed on your desk very frequently—the legal cost of that would continue to mount.

The other thing is, it is my understanding that, if that same right of action is not there for patients through the Medicare program, that would have some right of action against the Federal Government.

Now, I am not an attorney, but you would think that, if you were going to support it for one level of government, you would support it for another.

Senator HATCH. I see. If the last two could comment, if you have any comment?

Dr. VLADECK. Senator, I would just point out that there was a private right of action for providers and beneficiaries to enforce the Medicaid law against the States in Federal courts until the Supreme Court's *Gonzaga* decision in 2002 overturned 100 years' worth of jurisprudence.

But from 1966 through 2002, there was a private right of action in the Medicaid program. Costs grew no faster during that period than they have in recent years or in future projections for costs.

So the notion that it would have an impact on the costs of the Medicaid program for either the States or the Federal Government that would be more than a blip relative to what is already projected, it seems to me, is inconsistent with the historical record.

Senator HATCH. Take it from me, Dr. Vladeck, we are living in a different age right now, and it is an age of litigation. And I guarantee you this would be one of the biggest boondoggles for attorneys that I have ever seen in my life. And the past really is not relevant.

Thanks.

The CHAIRMAN. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Mr. Chairman, I also want to commend you. I think this has been an excellent hearing. We have gotten a lot of important information out, and I commend you for it.

Gentlemen, we have spent 2 hours, and we have been talking about copayments, we have been talking about premiums, and I want to make my last question a question about what you all believe we ought to do on the issue that really involves where all the money goes.

As you know, where all the money goes is chronic care. And these numbers just take your breath away. There was one analysis that indicates something like 10 percent of the population consumes about 60 percent of health care costs, and then there is another that says 20 percent consumes about 80 percent, and that is where the money goes.

That is where the money goes for Medicare, and that is where the money goes for the health care system as a whole.

Now, through particularly Chairman Baucus's support, we took some baby steps in the health reform bill to start getting care for those chronic patients at home. We got the Independence at Home program, but they really are baby steps.

So every single night in America, every night, we have folks, older people, going in ambulances to hospital emergency rooms who could be treated at home and get a higher quality of life for less cost.

And what I wanted to ask the two of you is, part of this issue of entitlement, cost control and ensuring that there is quality, do you not think that Congress ought to get back in and expand dramatically, dramatically, programs like Independence at Home and make a much more systematic and comprehensive effort to get chronic care to folks at home rather than in institutions? And, unless there is an effort to focus on this now—I think I was co-director of the Oregon Gray Panthers when Chairman Rockefeller was trying to do more on this question of care at home.

So this is not going to get done unless there is a bipartisan effort to recognize that this issue has gotten short shrift for too long and it is absolutely essential to containing costs and increasing quality.

And I thought I would wrap up with the two of you, Dr. Vladeck, and you, Dr. Holtz-Eakin. What are your thoughts on getting this country serious about addressing chronic care, particularly by getting folks out of institutional services and into home care?

Dr. Vladeck, and then you, Doctor.

Dr. VLADECK. Senator, I agree entirely with your principle, and I have been very much involved in seeking to get some of the provisions that speak to this in the Affordable Care Act into practice.

I think we need to expand the programmatic opportunities, but I think there is something else that needs to be done, as well, if I may.

One of the major barriers to improving the system for the chronically ill in the ways you are discussing is, we have a terrible shortage of expertise and competence among our health care professionals on how to do this.

Physicians, most physicians have never made a house call, and they did not get training in house calls during their residencies or when they were medical students.

As we have dealt with budgets over the last decades, we have shaved and shrunk our appropriated support for a whole variety of important potential activities, such as the training of physicians and the training of nurses and the training of other health professionals, and, if we are going to build the system that addresses the needs of the chronically ill more effectively and more cost-effectively, we are going to need health care professionals who know how to do it.

And, without some additional help from the Federal Government, that will not happen nearly quickly enough.

Dr. HOLTZ-EAKIN. I want to endorse the focus. There is no question about it. That is where the money is. I want to endorse the notion that Medicare is the right Federal policy place to drive delivery system changes.

And there is lots of disagreement on both sides of the aisle about what those policy levels should be, but I do not think there is any disagreement that Medicare has a tremendous capacity to change the way we deliver health care and, in particular, the management of chronic diseases, whether or not you do it within the current structure, where you would have to somehow engage the home health community in efforts to avoid inpatient stays and after discharge, readmissions.

They have to be part of that conversation, and the programs have to give them incentives to do that. So, bundling across those sort of silos would be an improvement in the current system or more dramatic reforms that put the money in the hands of beneficiaries and said, "Look, coordinate my care, take care of me, keep me out of the hospital."

But something has to happen, and I agree it should be bipartisan, because the sad reality is, if it is not, it will not be durable, and we need big fixes that last.

Senator WYDEN. That was my point. And my time is up, Mr. Chairman. I thank you for this extra question.

I hope the two of you, in particular—because, if there is not a new effort to generate political will on this, we will be back here in 10 years talking about exactly the same thing that Senator Rockefeller was trying to get us focused on literally 3 decades ago.

The CHAIRMAN. Senator Rockefeller?

Senator WYDEN. Thank you.

Senator ROCKEFELLER. Let me make three points. One, Dr. Holtz-Eakin, the idea that they voted to privatize Medicare, they have backed off from that. The 26th District of New York somehow had an amazing effect, and now they are not talking about it, but they voted for that.

So you get this very interesting thing of where Republicans—and this sounds political, but I am really not feeling that. They are trying to privatize Medicare, hand it over to the whims of the private health insurance companies, but they are opposing IPAB.

Now, let me explain what I mean. The average senior citizen makes \$22,000. If Medicare was somehow privatized, they would

have to spend \$6,400 more than they currently do to go out and buy health insurance. They cannot do that. So it will not work.

Now, let me go to IPAB. Dr. Bruce Vladeck, I am an enormous fan of yours. It seems like 3 weeks ago that you were here. But I am going to win you over to IPAB if it is the last—if I have to come—where are you living? You are living in Boston?

Dr. VLADECK. New York.

Senator ROCKEFELLER. New York. [Laughter.]

Well, that is good. I will be up to see you. But let me give you an example. What I think one of our main problems is in this whole discussion of not just health care, but in general, is that the solutions are enormous and complicated and take an enormous amount of time. You made that point.

We cover 32 million people in Senator Baucus's Affordable Health Care Act, but we did not do it until 2020, because we did not have the money.

Well, we do not have any money now, but there is going to come a day when we do. Our problem is that we treat potential solutions in health care on, like, a short-term basis. We are going to react as we would to, "Oh, you are going to take away my highway, are you? Well, I am going to fight you."

In other words, you have to sort of stand back and say this is going to be a 15- to 20-year process and it is not just about Medicare or Medicaid, it is about what is going to work for the long-term.

So my statement about IPAB: I had 30 major hospital directors in my office for an hour and a half as they clobbered me over the concept of the Independent Payment Advisory Board, which, as I say, was a Republican idea.

Then all of a sudden, I used two of the people I talked to about it, and I said to one of them, "Well, wait a second now. You do not trust the Congress, but you get a lot of money from them, probably more than you should. We know you have to save money. You know that system is not a really good one. You come here and you meet and you have your hospital association meetings or whatever meetings, and you have to get a good speech from a Republican and get a good speech from a Democrat, then you spend the next 3 days going up on the Hill and trying to ratchet all the money you can out of every single person whom you are assigned to go see. This is not called a solution for lowering health care costs."

And then I said, "Well, what if IPAB, the membership, were made up of people like Gail Wilensky or Stuart Altman, a lot of this generation?" And, they said "Oh, that would be fine."

In other words, there is the prejudice, the hunkering down, the prejudice that any change in patterns and habits would lead us astray and would not be to their advantage as opposed to somebody who really, like yourself, who really knows this stuff and who can postulate on it and make wise decisions.

Now, next question. There would have to be a bureaucracy. So they have to trade off. There is a bureaucracy to make sure that you are really doing the right thing on reimbursing anesthesiologists as opposed to pediatricians and all the rest of it.

Yes, there would have to be. So we need to adjust to that, because the tradeoff is, do we solve the problem for the future or do we simply make short-term counter-punches?

Final point—and this is really radical. But you have all talked about people, doctors not wanting to serve Medicaid patients. I have a lot of experience, and we all do, with people trained to be geriatricians, but then they do it for 2 years, but they just cannot make any money there, because of their debts, which are huge, from medical education.

So they go into some other higher-paying specialty. One thing to think about, and this will not happen for 15 or 20 years, at best, and we would have to be a very healthy economic country: if you want people to follow their real instincts, a lot of them want to be primary care doctors in very rural areas. They want to be geriatricians, but they cannot afford to be.

So you know what you do? You pay for their education, and it only costs a couple billion dollars a year, \$3 billion or \$4 billion a year. We cannot do that now. But just think about that. That would solve a whole series of questions which we are not addressing and we cannot address now.

So I will end just by saying we have to think large. I am going to fight for Medicaid, Governor.

The CHAIRMAN. I am sorry. We are going to have to end this hearing. Speaking of thinking large, that concept is a very big one.

Senator ROCKEFELLER. I will end on that.

The CHAIRMAN. Good way to end this hearing. I might say, some countries do pay for education, medical education. Some other countries do.

Thank you, Senator. The hearing is adjourned.

[Whereupon, at 12:11 p.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.) Regarding Rising Costs in Medicare and Medicaid

Eleanor Roosevelt once said, "One's philosophy is not best expressed in words; it is expressed in the choices one makes...and the choices we make are ultimately our responsibility."

Today the Finance Committee holds its fourth hearing examining the choices surrounding the budget and reducing the federal deficit. This morning we focus on our health care choices, specifically Medicare and Medicaid.

According to the Congressional Budget Office, 20 years ago, Medicare and Medicaid represented nearly 12.6 percent of total federal spending. By 2035, that number is expected to grow to about 33 percent, almost triple. For the continued health of Medicare and Medicaid – and the health of our budget – we must address this growth.

What is causing these two programs to grow so fast? The most significant contributor is rising health care costs.

For the past several decades, health care has been inefficient. Too often, physicians didn't coordinate care, seniors bounced between hospitals and nursing homes without being properly treated, and preventive services were underutilized. As a result, health care costs skyrocketed.

Another factor is our aging population. Nearly 80 million Americans are part of the "baby boom" generation and this year, they start to become eligible for Medicare. As a result, enrollment in Medicare will accelerate. In fact, 9,000 "boomers" turn 65 every day.

To slow the growth of Medicare and Medicaid, we have two choices: curb the growth of health care costs or shift the burden onto an aging population.

Health reform represents the first of these two choices. The new law reins in costs and makes our health care system more efficient. Reform begins to change how Medicare pays for health care. Instead of paying based on the number of services, Medicare now rewards doctors and hospitals for health care that delivers real results for patients.

It pays for quality versus quantity, and by investing in prevention, health reform saves money and saves lives. The health reform law also saves millions of taxpayer dollars by rooting out fraud and ending costly overpayments to private health insurance companies.

Thanks to these reforms, the health reform law resulted in the most significant deficit reduction in more than a decade. According to the non-partisan Congressional Budget Office, or CBO, health reform will reduce the deficit by \$210 billion in the next ten years, and by more than one trillion dollars in the decade that follows.

The House budget, on the other hand, makes the second choice. That budget ignores rising health care costs. Instead, it places the burden squarely onto the shoulders of seniors.

First, the House budget eliminates benefits seniors count on to pay for medicine they need. It re-opens the Medicare Part D coverage gap, known as the donut hole, which health reform finally closed. Eliminating this coverage would force seniors to pay more for the prescription medicines they need.

Second, the House budget would cut more than \$700 billion from nursing homes and other Medicaid services. States would be handed a block grant to run their programs with zero accountability. There would be no guarantee of nursing home access or other care for those who need it the most.

Finally, as the Wall Street Journal noted, the House Budget would “end Medicare as we know it.”

The House budget would end Medicare’s guaranteed benefits.

Instead, it would provide seniors with a voucher to purchase private insurance. Under this system, private insurance companies would be able to charge more based on a person’s age. And the voucher wouldn’t come close to meeting seniors’ needs.

According to CBO, “most elderly people would pay more for their health care than they would pay under the current Medicare system.”

How much more? The CBO estimates that under the House budget, the average 65 year-old would have to pay \$12,000 a year out of their own pocket just to receive the same benefits Medicare offers today.

It is clear that the health reform law and the House budget offer two distinct choices. Health reform makes our health care system more efficient and reduces costs. The House budget shifts costs to seniors and states.

So let us make the right choices as we work to reduce the deficit. Let us work together to protect seniors and reduce health care costs. Let us continue to improve our health care system to make it more efficient. Let us make the choices that reflect America’s priorities. And, to heed Eleanor Roosevelt’s advice, let us be responsible for the choices we make.

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CONGRESSIONAL TESTIMONY

Testimony before

**The Committee on Finance
United States Senate**

“Health Care Entitlements: The Road Forward”

June 23, 2011

**The Honorable Ernest Lee Fletcher, M.D.
Former Governor, Commonwealth of Kentucky**

Chairman Baucus, Ranking Member Hatch and Senators of this august body, thank you for the opportunity to share some of my thoughts with you today.

Prior to 15 years of public service both in the legislative and executives branches in Washington and in Kentucky, I practiced primary care medicine. I am currently the chief executive officer for Alton Healthcare. Alton provides lean practice management, consultation, electronic health records and information technology development focused on primary care to provide more efficient quality care. To meet our goal for our patient to – *Live Longer, Live Healthier*, we focus on primary and secondary prevention including the detection and treatment of early microvascular disease in order to reduce heart attacks and strokes.

It is great to be back in these halls, I never lose my awe of this place.

Regardless of party affiliation, we all know that our health care system needed reform. We have coverage gaps, entitlement program spending is skyrocketing, and the cost of health care is far too high.

A concise way of stating a broadly shared goal is reflected in the Triple Aim: Better care, Better health, and Lower cost.

Political differences lie primarily in how we reach those noble goals and how we measure success.

It is not only those who serve us here in the nation's capital, but also those who serve closer to people's everyday lives that address the challenges of reaching these goals.

The Medicaid program is a prime example. And there is no question it needs reform to address access and to lower spending for both states and the federal government.

According to the actuary at the Centers for Medicare and Medicaid Services, taxpayers spent \$404.9 billion on the Medicaid program last year and the size of the program will more than double to \$840.4 billion by 2019. And by 2019, the state share of that spending will be almost \$330 billion. Clearly, the costs of Medicaid put tremendous pressure on state budgets.

As with many other governors, in Kentucky I faced an empty rainy day fund and a projected debt of nearly 10% of the budget. As many states are doing today to solve even more challenging shortfalls, I had to examine the areas of the largest expenditures: healthcare and education.

It was quite a transition from my days here on Capitol Hill where I served on the House Energy and Commerce Committee. We could not borrow from the future nor could we print money. We examined bonding non-capital spending, but concluded that the resulting downgraded bond ratings with its higher interest rates would increase future debt payments and only compound the problem – a problem that has not only plagued those states that went that route, but also our nation.

Currently governors face a total projected shortfall of \$175 billion over the next two years. The \$151 billion in flexible emergency funding that the American Recovery and Reinvestment Act of 2009 (ARRA) provided has expired, and now governors across the country are facing deep spending cuts or tax increases to balance their budgets.

The *Washington Post* recently noted that states are facing “the most severe budget crisis since the Great Depression.” The article also noted, “New York Gov. Andrew M. Cuomo (D) called his state ‘functionally bankrupt’ as he proposed closing most of a \$10 billion budget gap by reducing funding for education and Medicaid.”

Medicaid is the lion's share of that spending burden as it now consumes about 22 percent of state budgets now and will consume \$4.6 trillion of Washington's budget over the next ten years.

Our national debt is mounting. In fact, if we do not change our course we will be paying more on the national debt interest than we spend on Medicaid within six years.

Governors also realize that Washington's own budget situation prevents it coming to the states' rescue yet again – our nation is in no position to bail out the states.

I realize that Washington is broke so there will not -- and should not -- be more state bailout money from Washington. But what states – and the federal government – need to do is take a hard look at how to lower Medicaid spending.

To meet the challenges of Medicaid in Kentucky, we began the long waiver process hoping for flexibility to do the right thing for our beneficiaries and taxpayers. While Section 1115 waivers hold the potential to give tremendous flexibility to states, these waivers can take years to obtain and are subject to the politics of a particular Administration. The time spent on obtaining those waivers from Washington could be better spent on solving our healthcare problems.

Then the Deficit Reduction Act passed in 2005. Kentucky and our neighbor West Virginia were the first states to take advantage of that Act. In Kentucky, with this newfound liberty, we were free to focus on healthcare instead of navigating through the regulatory jungle of outdated models of the past.

We were very pleased with the Deficit Reduction Act for Medicaid and SCHIP populations, and we established *KyHealth Choices* to increase service delivery choices for adults with developmental disabilities, acquired brain injuries, physical disabilities and for the frail and elderly. The new approach provided real choices around accessing long-term care services with an emphasis placed upon receiving the *right care, in the right setting, at the right time*. We introduced proven private health insurance principles, including utilization and intense disease management to ensure that appropriate services and drugs were provided based on medical necessity.

We took calculated business risks. Many of the programs included greater initial costs or reimbursement for services that were not traditionally covered in order to improve health outcomes for individuals and avoid more expensive future health expenditures.

Consumer-directed care was a critical piece of encouraging more personal responsibility and involvement and offering more choice, freedom, independence and self-determination in Kentucky's assistance programs.

We tailored provider reimbursement increases to improve access and to insure quality physicians would care for our patients.

I am concerned that many of the flexibilities that allowed governors to innovative win-win solutions are being taken away piece by piece. Many of the successes we implemented in Kentucky may not be possible for other states today.

The maintenance of effort (MOE) requirement, which had never been a part of Medicaid, took away state flexibility to manage eligibility in their programs. States are prohibited from changing "standards, methodologies, or procedures," which is so prescriptive it prohibits states from even making program integrity modernizations.

I – along with the majority of current governors – support legislative efforts to repeal the MOE requirements in order to give governors the flexibility to target scarce dollars to the beneficiaries who need help the most.

Second, the Medicaid expansions in the Patient Protection and Affordable Care Act (PPACA) put what is simply an unrealistic burden on the states. For the Commonwealth of Kentucky, the Medicaid expansions are estimated to cost \$675 million. And nationwide, they will mean at least a \$118 billion new burden on all states through 2023. That means proven

programs like Kentucky's "Read to Achieve" which focuses on early childhood literacy is cut or eliminated. Without that help many of our children will fall into the abyss of hopelessness and failure.

Third, the Administration has proposed a new set of regulations for states looking for savings in spending on Medicaid providers. While the goal of ensuring access to care is noble, states need the flexibility to set their own rates in a manner that balances both their budget realities and adequate access.

When I was governor, we raised rates to certain providers. But sometimes it is the right thing –and the necessary thing – for governors to lower rates. States – not bureaucrats in Baltimore – are closest to Medicaid patients and providers and are in the best position to make those decisions.

On top of all of this, a court case that will be heard by the Supreme Court this fall could dramatically increase litigation and the associated costs for states. All of these issues make it increasingly difficult for governors to focus on tailoring their Medicaid programs in ways that meet the needs of their citizens.

Governors are close to the challenges and the problems. Give them the freedom to address the challenges, and they will find remarkable success and fair solutions. "Welfare to Work" – developed under the leadership of Governor Tommy Thompson, Mike Leavitt, and others – provided a proven model as Congress enacted bipartisan Welfare reform with President Clinton.

The innovation of the states freed to focus on caring for our vulnerable will result in solutions that meet our shared goals. I have found that often the folks working at our state capitols have worked on Medicaid for years and know many of the solutions, but must be given the freedom and tools to implement them.

My experience, as both a Member of the House of Representatives here and as a Governor back in my home state, is that top down, one-size-fits-all management from Washington does not work. However, setting expectations with clear goals, guidelines, and measured results will motivate and inspire leaders who will rise to meet the challenges.

The Obama Administration's healthcare overhaul is very prescriptive and allows little flexibility. It looks to Washington for the solutions rather than empower those on the ground across the nation who have their hand on the till to find solutions that match specific needs. Patients challenges in the hills and hollows of Appalachia are very different than those in inner city New York.

Having viewed Medicaid's problems as a family physician, as a legislator on Capitol Hill, and as the Governor of a state with unique health care challenges, I strongly recommend that you take the approach of a facilitator. You certainly have the power to take a dictatorial role, but that has not solved our problems in Medicaid; in fact, it has made them worse.

Medicaid is not working very well. Not only do waste, fraud, and abuse plague our current system, but the program does not serve patients well. I know this as a family physician who has treated patients from all walks of life, and I know this as someone who studies the latest peer-reviewed medical literature.

For example, a study published recently in the *New England Journal of Medicine* found "found significant disparities in provider acceptance of Medicaid–CHIP versus private insurance across all tested specialties." Specifically, the study found that "Overall, 66% of Medicaid–CHIP callers... were denied an appointment as compared with 11% of privately insured callers ... Among 89 clinics that accepted both insurance types, the average wait time for Medicaid–CHIP enrollees was 22 days longer than that for privately insured children."

In some research, even patients without any insurance do the same or better than those on Medicaid.

According to a 2010 study in the journal *Cancer*, Medicaid and uninsured patients with cancer of the throat were 50 percent more likely to die than privately insured patients.

According to a 2011 study in the *American Journal of Cardiology*, Medicaid patients undergoing coronary angioplasty were nearly 60 percent to have major adverse events than privately insured patients.

According to a 2011 study in the Journal of Heart and Lung Transplantation, certain Medicaid patients undergoing lung transplants had a significantly lower 10 year survival rate compared to privately insured and even uninsured patients.

And these studies represent only the treatment failures. They do not begin to address wellness and prevention shortcomings.

There are solutions to these problems that states understand better than any bureaucrat, and need only the freedom to implement these proven innovations.

For example, in Northern Virginia's Care First Plan by Anthem, CEO Chet Burrell with his team is making a real difference.

They stratified their patients and, according to Chet Burrell, found that:

- Those with "Advanced Illness" constitute 3% of the population and accounted for 29% of the cost.
- 7% had Multiple Chronic Conditions and accounted for 23% of the cost.
- 10% were defined as "At Risk" and accounted for 19% of the cost.
- 30% were defined as "Stable" and accounted for 22% of the cost.
- The remaining 50% were defined as "Healthy" and accounted for only 7% of the cost.

They hired Regional Care Coordinators and Local Nurse Coordinators to work with Primary Care Physicians to focus on the most ill.

They have seen not only better care but also lower costs.

They share realized savings with the Primary Care providers, and this incentive is working.

They recognized that only 6 percent of healthcare spending goes to pay primary care and yet primary care physicians make the two most important decisions: when to refer and to whom to refer.

Another example was the subject of a *New Yorker* magazine article back in January entitled "The Hot Spotters." It is about a primary care doctor, Dr. Jeffrey Brenner in Camden, New Jersey, that dared to be different.

His calculations revealed that 1 percent of the hundred thousand people who made use of the Camden's medical facilities accounted for 30% of the cost.

Fighting the bureaucracy hampered and slowed his progress, but he eventually got access to the information on patients he needed.

Dr. Brenner and his Camden Coalition have been able to measure long-term effect on his first 36 super utilizers: "Those patients averaged 62 hospital and ER visits per month before the program and 37 after joining. Their hospital bills averaged \$1.2 million per month before and just over half a million after--a 56% reduction."

Another model, the patient-centered medical home is being piloted across the country and is proving to provide better care and in some cases realize savings of up to 20 percent. The new health care law makes cursory mention of the medical home on one hand, but takes away flexibility to effectively implement it on the other.

As these examples illustrate there are some proven models to save cost and deliver better care, but states currently do not have the flexibility to prioritize their limited dollars.

Without the flexibility states may not be able to direct money from mandated areas to take advantage of these proven models. And states may have to follow Washington's prescriptive regulations that could thwart implementation of an otherwise good idea.

Earlier I mentioned education and healthcare as the two frequently targeted areas when having to make budget cuts, and Governor Cuomo referenced these as targeted areas of budget cuts for New York. The fact is that governors have few choices now of where to save money and with mounting Washington mandates they will have even fewer.

The ability to make targeted cuts and to tailor programs is important -- not only because they are the big-ticket spending items in a state budget, but also because they are interrelated. Poorer healthcare reduces school performance, and lower educational levels are associated with poorer healthcare outcomes.

When mandates further limit states by requiring them to spend money in a prescribed way it strangles innovation. Flexibility will give them a choice to implement innovative methods that can truly save money, provide better services to their constituents, and target scarce resources to the most vulnerable in our society. Reform does not have to be the zero sum game that health care reform has created.

PPACA established a Center for Innovation within CMS to talk about transforming our broken fee-for-service system and addressing the worthy goal of promoting innovation. However, the problem is that this Center is premised on the flawed idea that innovative solutions must come from bureaucrats in Washington.

This Obama Administration's signature delivery system reform -- Accountable Care Organizations -- was modeled after high-quality, integrated care facilities across the country like Geisinger and Mayo. But when CMS tried to proscribe this private-sector innovation through a 400 plus page rule, even the Geisingers and Mayos of the world told Washington it would not work. Washington is in no better position to develop solutions for each state's unique Medicaid program and patient populations. When it comes to Medicaid, solutions best come from States who are closest to the needs and challenges of their citizens.

Medicaid is in dire need of reform. It is bankrupting both states and the federal government, while failing patients. I recommend eliminating restrictive mandates, such as the maintenance of effort requirements, and granting the states the freedom to be creative and implement what works. More broadly, Washington should establish clear goals, guidelines, and defined budgets, but then empower 50 sites of innovation across the nation.

You will be providing the most vulnerable a much better healthcare system.

**STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF JUNE 23, 2011
HEALTH CARE ENTITLEMENTS: THE ROAD FORWARD**

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, released his opening statement from a committee hearing today examining the solvency of health care entitlement programs. Hatch has said it is imperative to keep entitlements – the largest drivers of the nation’s debt – on the table during deficit reduction discussions.

A full copy of Hatch’s remarks, as prepared for delivery, follows:

I want to thank Senator Baucus for convening this hearing. The clock is ticking. Every day that passes that we don’t act to rein in federal spending and address our entitlement crisis leaves taxpayers exposed to unacceptable and unsustainable levels of debt. Simply doing nothing is not an option.

These problems are fundamental, and they will not fix themselves. We owe it to our seniors, children, and grandchildren to get off the sidelines and act responsibly to fix this problem.

Our fiscal situation is dire. We have now had three consecutive years with trillion dollar deficits, and we have racked up a \$14 trillion debt.

For any who doubted the magnitude of this crisis, the CBO confirmed it again yesterday. By 2035 our public debt will rise to 190 percent of gross domestic product if we do not get spending under control.

We cannot allow this to happen. Right now we are on a glide path to Greece — a path with devastating implications for the liberty of taxpayers and the prosperity of this nation.

Admiral Michael Mullen has identified our current debt spiral as the single greatest threat to our national security.

It is hard for me to disagree.

The bottom line is that the storm is gathering, and a commitment to the entitlement status quo is a commitment to senior impoverishment and national bankruptcy.

Last year alone, total Medicare and Medicaid spending was \$800 billion. The longer we wait to address these programs’ finances the harder they will be to solve. The time for courage is now. This year the first baby boomer will become eligible for Medicare. In 2010, there were 47 million Medicare beneficiaries alone, and by 2031 it’s projected that 80 million people will be Medicare eligible. As these retirees come online, government spending is going to mushroom.

According to this year's Medicare Trustees Report, Medicare is facing a \$38 trillion unfunded liability. This number is so outlandish that I need to put it in perspective.

The median household income is \$49,777 per year. The median home value now stands at \$221,800, which we all know is the biggest asset most families will ever own. Yet, Medicare's unfunded liability stands at an astonishing \$353,350 per household. So even if an average family sold their home and gave up their income for an entire year, they would still not meet their share of this one entitlement obligation. This is simply unacceptable.

Today, our three major entitlement programs — Medicare, Medicaid, and Social Security — account for 44 percent of non-interest Federal spending. But by 2085, these three entitlement programs could account for more than 60 percent, or two-thirds, of the federal budget.

We have seen this train coming down the tracks for some time. Yet given the opportunity to address this fiscal imbalance in a responsible way, the President raided the already busted Medicare program. The Patient Protection and Affordable Care Act increased spending by \$2.6 trillion, created new entitlements and expanded old ones, and attempted to pay for all this by stripping Medicare of \$529 billion and raising taxes by over \$800 billion.

Guided by a political philosophy of *never letting a crisis go to waste*, this law has only helped to accelerate our current debt crisis.

To get Medicare spending under control, the President is going to have to lead. He is going to have to put national priorities over presidential politics and address entitlement spending. Unfortunately, the President's solution is to grant power to a 15-member panel of bureaucrats that will decide how to spend taxpayer dollars and to determine what care our senior citizens will receive.

And let me be 100 percent clear. The Independent Payment Advisory Board, or IPAB, is not the solution to Medicare's coming bankruptcy.

As bad as Medicare's financing is, it is only one contributor to our growing debt crisis. Medicaid is also a growing burden on the federal and the state governments. The Medicaid program has grown far beyond its original purpose of being a safety net for the most vulnerable in our society.

As weak as Medicaid's financing already was, the health care law that passed over the objection of every Senate Republican resulted in the biggest expansion of Medicaid in its history. According to CMS, in 1966, there were only 4 million Medicaid enrollees, but by 2019, there will be 78 million. And just this week we learned that the new health care law, through an unintended glitch, will actually expand Medicaid to an additional 3 million middle class Americans making up to \$64,000.

That's some glitch.

This mission creep is bankrupting the federal government. Washington will spend \$4.6 trillion on Medicaid over the next 10 years — a huge driver of our national debt. To put it delicately, the new health care law certainly did not help. The office of the Actuary at CMS estimates that the Medicaid expansion will cost federal taxpayers \$735 billion over the next 10 years.

And cash-strapped states are also feeling the burden of the Medicaid entitlement. The program consumes nearly 22 percent of states' budgets today, and things are about to get a whole lot worse.

A Joint Congressional Committee report that I authored with Chairman Fred Upton found that states are estimating they'll have to spend another \$118 billion because of this new law.

To maintain these expansions will require cuts in other programs like education, public safety, and other health services.

Many factors will continue to drive up Medicaid spending, such as the onerous maintenance of effort requirements, the Administration's proposed rate regulations that set up new bureaucratic hurdles for states to manage their programs, and a court case before the Supreme Court this fall that could lead to a new wave of costly litigation.

There is simply no use denying the obvious. Medicaid is in need of major reform. And instead of centralizing power in the nation's capital, Congress should set broad guidelines and defined budgets, but then empower the states to run their Medicaid programs in a manner consistent with the needs and the values of their citizens.

Entitlement reform is not about cutting providers just for the sake of cutting. Medicare, Medicaid, and Social Security face real problems that demand structural changes. Our citizens need these changes, and the markets are demanding them.

Last winter, I heard a Democratic House member state that *the Republicans won in November and therefore it's their job to fix entitlements*.

Let me be very clear. It's all of our jobs to fix entitlements. And history will not look kindly on those who stood on the sidelines during the central debate about the future of this nation.

And so, Senator Baucus, thank you for convening this hearing today. I look forward to hearing from our witnesses and a serious discussion about the need for meaningful reform.

###

A Budget Buster

Entitlement Spending as a % of Non-Interest Federal Spending

Without Reforms, Nearly 2/3 of Federal Budget Will Go Towards Entitlements

60%

44%

30%

1980

2010

2035

Source: White House, President's 2011 Budget

PPACA Medicaid Expansion



By Enrollment
Source: Center of the American Budget, Center for Medicaid and CHIP Services

Medicaid Mandate on Cash-Strapped States = **\$118** Billion



Source: 2007 Congressional Budget Office Medicaid Expenditure

The Future of Medicare

Testimony before the United States Senate
Committee on Finance

Douglas Holtz-Eakin
President, American Action Forum*

June 23, 2011

*The views expressed herein are my own and do not represent the position of the American Action Forum. I thank Nathan Barton, Emily Egan, Hanna Gregg, Carey Lafferty, Michael Ramlet, and Matt Thoman for their assistance.

Chairman Baucus, Ranking Member Hatch and Members of the committee, thank you for the privilege of appearing today. In this written statement, I hope to make the following points:

- Medicare must be reformed. The *status quo* is dangerous to the fiscal health of the federal government, the U.S. economy, and especially Medicare beneficiaries.
- Medicare is at the heart of the debt explosion that dominates the federal budget outlook.
- The federal debt explosion represents a severe economic risk that threatens national security and our future economic and job growth in the United States.
- Under current law, Medicare providers are likely to depart the market reducing access for beneficiaries. If reimbursement rates fall as in Medicaid, we will see the same kind of dramatic health consequences.
- The Independent Payment Advisory Board is a dramatic policy error that will exacerbate reimbursement problems and stifle innovation.

Let me discuss each in turn.

1. The status quo is dangerous because Medicare contributes greatly to the fiscal problems facing the Federal government.

Medicare as we know it is financially unsustainable. The reality is that the combination of payroll taxes and premiums do not come close to covering the outlays of the program. As shown in Table 1, in 2010 Medicare required nearly \$280 billion in general revenue transfers to meet its cash outlays of \$523 billion. As program costs escalate, the shortfalls will continue to grow and reach a projected cash-flow deficit of over \$600 billion in 2020.

These shortfalls are at the heart of past deficit and projected future debt accumulation. As shown in Table 2, between 1996 and 2010, cumulative Medicare cash-flow deficits totaled just over \$2 trillion, or 22 percent of the federal debt in the hands of the public. Including the interest cost on those Medicare deficits means that the program is responsible for 23 percent of the total debt accumulation to date.

Going forward, the situation is even worse. By 2020, the cumulative cash-flow deficits of 6.2 trillion will constitute 35 percent of the debt accumulation. Again,

appropriately attributing the program its share of the interest costs raises this to 37 percent.

Viewed in isolation, Medicare is a fiscal nightmare that must change course. When combined with other budgetary stresses, it contributes to a dangerous fiscal future for the United States.

2. The status quo is dangerous because the federal debt explosion represents a severe economic risk that threatens economic and job growth in the United States.

The federal government faces enormous budgetary difficulties, largely due to long-term pension, health, and other spending promises coupled with recent programmatic expansions. The core, long-term issue has been outlined in successive versions of the Congressional Budget Office's (CBO's) *Long-Term Budget Outlook*.¹ In broad terms, over the next 30 years, the inexorable dynamics of current law will raise federal outlays from an historic norm of about 20 percent of Gross Domestic Product (GDP) to anywhere from 30 to 40 percent of GDP.²

This depiction of the federal budgetary future and its diagnosis and prescription has all remained unchanged for at least a decade. Despite this, action (in the right direction) has yet to be seen.

In the past several years, the outlook has worsened significantly.

Over the next ten years, according to the Congressional Budget Office's (CBO's) analysis of the President's Budgetary Proposals for Fiscal Year 2012, the deficit will never fall below \$740 billion.³ Ten years from now, in 2021, the deficit will be nearly 5 percent of GDP, roughly \$1.15 trillion, of which over \$900 billion will be devoted to servicing debt on previous borrowing.

As a result of the spending binge, in 2021 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory.⁴

¹ Congressional Budget Office. 2011. *The Long-Term Budget Outlook*. Pub. No. 4277. http://cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf

² Congressional Budget Office. 2011. *The Long-Term Budget Outlook*. Pub. No. 4277. http://cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf

³ Congressional Budget Office. 2011. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2012*. Pub. No. 4258. <http://www.cbo.gov/ftpdocs/121xx/doc12130/04-15-AnalysisPresidentsBudget.pdf>

⁴ Congressional Budget Office. 2011. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2012*. Pub. No. 4258. <http://www.cbo.gov/ftpdocs/121xx/doc12130/04-15-AnalysisPresidentsBudget.pdf>

A United States fiscal crisis is now a threatening reality. It wasn't always so, even though – as noted above – the Congressional Budget Office has long published a pessimistic *Long-Term Budget Outlook*. Despite these gloomy forecasts, nobody seemed to care. Bond markets were quiescent. Voters were indifferent. And politicians were positively in denial that the “spend now, worry later” era would ever end.

Those days have passed. Now Greece, Portugal, Spain, Ireland, and even Britain are under the scrutiny of skeptical financial markets. And there are signs that the U.S. is next, as each of the major rating agencies have publicized heightened scrutiny of the United States. What happened?

First, the U.S. frittered away its lead time. It was widely recognized that the crunch would only arrive when the baby boomers began to retire. Guess what? The very first official baby boomer already chose to retire early at age 62, and the number of retirees will rise as the years progress. Crunch time has arrived and nothing was done in the interim to solve the basic spending problem.

Second, the events of the financial crisis and recession used up the federal government's cushion. In 2008, debt outstanding was only 40 percent of GDP. Already it is over 60 percent and rising rapidly.

Third, active steps continue to make the problem worse. The Affordable Care Act “reform” adds two new entitlement programs for insurance subsidies and long-term care insurance without fixing the existing problems in Social Security, Medicare, and Medicaid.

Financial markets no longer can comfort themselves with the fact that the United States has time and flexibility to get its fiscal act together. Time passed, wiggle room vanished, and the only actions taken thus far have made matters worse.

As noted above, in 2020 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory. Traditionally, a debt-to-GDP ratio of 90 percent or more is associated with the risk of a sovereign debt crisis.

Perhaps even more troubling, much of this borrowing comes from international lending sources, including sovereign lenders like China that do not share our core values.

For Main Street America, the “bad news” version of the fiscal crisis would occur when international lenders revolt over the outlook for debt and cut off U.S. access to international credit. In an eerie reprise of the recent financial crisis, the credit freeze would drag down business activity and household spending. The resulting deep recession would be exacerbated by the inability of the federal government's

automatic stabilizers – unemployment insurance, lower taxes, etc. – to operate freely.

Worse, the crisis would arrive without the U.S. having fixed the fundamental problems. Getting spending under control in a crisis will be much more painful than a thoughtful, pro-active approach. In a crisis, there will be a greater pressure to resort to damaging tax increases. The upshot will be a threat to the ability of the United States to bequeath to future generations a standard of living greater than experienced at the present.

Future generations will find their freedoms diminished as well. The ability of the United States to project its values around the globe is fundamentally dependent upon its large, robust economy. Its diminished state will have security repercussions, as will the need to negotiate with less-than-friendly international lenders.

Some will argue that it is unrealistic to anticipate a cataclysmic financial market upheaval for the United States. Perhaps so. But an alternative future that simply skirts the major crisis would likely entail piecemeal revenue increases and spending cuts – just enough to keep an explosion from occurring. Under this “good news” version, the debt would continue to edge northward – perhaps at times slowed by modest and ineffectual “reforms” – and borrowing costs in the United States would remain elevated.

Profitable innovation and investment will flow elsewhere in the global economy. As U.S. productivity growth suffers, wage growth stagnates, and standards of living stall. With little economic advancement prior to tax, and a very large tax burden from the debt, the next generation will inherit a standard of living inferior to that bequeathed to this one.

3. The status quo is dangerous because Medicare will increasingly fail to provide access to quality care for beneficiaries.

Medicare coverage no longer guarantees access to care. Increasingly seniors enrolled in the Medicare program face barriers to accessing primary care physicians as well as medical and surgical specialists.

The physician access problem stems from Medicare's below-cost reimbursement rates and the uncertainty surrounding the Medicare sustainable growth rate (SGR) formula for physician payments. If the SGR were permitted to go into effect in 2012, physician services would face a reduction in payment of 29.4 percent.⁵

⁵ Congressional Budget Office. *Medicare's Payment to Physicians: The Budgetary Impact of Alternative Policies*. June 16, 2011.
http://cbo.gov/ftpdocs/122xx/doc12240/SGR_Menu_2011.pdf

While there is bipartisan agreement that the SGR formula needs to be fixed, the Patient Protection and Affordable Care Act (PPACA) failed to reset or restructure the fee schedule. As a result physicians are now faced with difficult decisions regarding whether to accept new Medicare patients or leave the Medicare market altogether.

In June 2010 Congress failed to pass a timely update to the SGR, and physicians were forced to begin making Medicare practice decisions. Table 3 shows the impact on physician access for Medicare enrollees as a result of the uncertainty created by the June 1, 2010 Medicare Part B payment reduction of 21.3 percent, which was later reversed by Congress. During the delayed SGR update, 11.8 percent of physicians stopped accepting new Medicare patients, 29.5 percent reduced the number of appointments for new Medicare patients, 15.5 percent reduced the number of appointments for current Medicare patients, and 1.1 percent of physicians decided to stop treating Medicare patients altogether.⁶

Recognizing the increased payment uncertainty caused by Congress' failure to enact a permanent SGR fix in 2010, physician practices have started to reshape their practice patterns. Moving forward 67.2 percent of physician practices are considering limiting the number of new Medicare patients, 49.5 percent are considering the option of refusing new Medicare patients, 56.3 are contemplating whether to reduce the number of appointments for current Medicare patients, and 27.5 percent are debating whether to cease treating all Medicare patients.⁷

Access problems for Medicare enrollees are not isolated to physicians. The nation's hospitals face a dire operating threat posed by the PPACA and the Independent Payment Advisory Board (IPAB).

Table 4 shows the hospital economic impact of the PPACA's inpatient hospital reimbursement cut on a sample of 401 non-profit stand-alone hospitals.⁸ After taking into account the pending reimbursement cuts, more than 232 hospitals of the 401 surveyed would begin operating at net loss. As the Chief Actuary of CMS, Richard Foster, has stated in his illustrative alternatives to the Medicare Trustees report, the pending payment reductions to America's hospitals is simply unsustainable. While the payment reductions create the illusion of budget savings, they dramatically undercut the viability of the nation's hospitals.

Table 5 indicates the potential impact of losing just 232 hospitals. Among the nation's non-profit standalone hospitals these payment reductions may lead to a

⁶ Medical Group Management Association. 2010. Sustainable Growth Rate Study. <http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=39774>

⁷ Medical Group Management Association. 2010. Sustainable Growth Rate Study. <http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=39774>

⁸ Moody's Investors Service. *Not-for-Profit Healthcare Medians for Fiscal Year 2009*. August 25, 2010.

loss of as many as 69,000 hospital beds and a loss of ER capacity totaling more than 14 million visits. If applied more broadly to the country's entire hospital infrastructure, the forced closure of as many as 55 percent of the nation's hospitals due to PPACA's payment reductions would threaten America's ability to respond to national disasters. Medicare's status quo is fraying the nation's social safety net.

4. The Independent Payment Advisory Board is a dramatic policy error that will exacerbate reimbursement problems and stifle innovation.

As noted above, reimbursement concerns will increasingly affect the care opportunities for Medicare beneficiaries. In light of this, one of the most dangerous aspects of the *status quo* is the creation of the Independent Payment Advisory Board (IPAB). It should be repealed immediately.

This appointed panel has been tasked with cutting Medicare spending, but its poor design will prove ineffective in bending the cost curve, and instead will lead to restricted patients' access and stifled innovation.

By statute, IPAB cannot directly alter Medicare benefits. Instead, the more likely threat to patients is that the IPAB will be forced to limit payments for medical services. So it could decide that patients should have coverage for one particular treatment option but not another, or must pay much more for one of the treatment options.

This is especially troubling because it may choose to focus on expensive new treatments. New medicines for conditions like Alzheimer's or Parkinson's will likely have rapid cost growth, especially early after their introduction. That will make them targets because the IPAB is directed to focus on areas of "excess cost growth." Worse, because about one-half of spending is off limits until after 2020, there will be a disproportionate and uneven application of IPAB's scrutiny and payment initiatives.

Because IPAB's cuts have to be achieved in one-year periods there will be an enhanced focus on reimbursements at the expense of longer-run quality improvements or preventive programs. In this way IPAB could actually discourage rather than encourage a focus on quality improvement.

All of this suggests that IPAB is a potent mechanism for undesirable policy. So it is particularly troubling that IPAB is unaccountable. Its decisions must be honored by the Secretary of HHS and it is structured to give Congress little ability to make the important policy choices.

The Independent Payment Advisory Board is at best a band-aid on out-of-control Medicare spending and at its worst a threat to physician autonomy and patient choice. Saving Medicare from ruin requires nothing short of total and

comprehensive reform. Adding in more cuts to a broken system does not make it any less broken. The IPAB proposals will be short-term fixes and cuts. We need long-term thinking and long-term solutions. We need to move the focus from merely containing costs to focus on how to get the most value for our health care dollars.

If Medicare's provider reimbursements are drastically reduced the market will react and, according to the basic laws of economics. Providers will have three options: to close up shop, to refuse Medicare patients, or to shift the costs onto the other patients. None of these options help our healthcare system operate more effectively or more efficiently.

Thank you and I look forward to answering your questions.

United States Senate Finance Committee
Hearing on “Health Care Entitlements: The Road Forward”
Thursday, June 23, 2011
Opening Statement for the Record by Senator John F. Kerry

Chairman Baucus and Ranking Member Hatch, thank you for providing me with the opportunity to introduce The Honorable Deval Patrick, Governor of the Commonwealth of Massachusetts.

Today’s hearing will examine the role of Medicare and Medicaid in federal deficit reduction. Let me just say that no other Governor in the nation can speak with the same authority on these programs in the context of universal coverage.

Governor Patrick has been tasked with implementing the landmark Massachusetts health reform law that was enacted five years ago. Before the Washington health reform debate began in 2008, the Bay State had already demonstrated to the rest of the nation that universal coverage was not just a moral imperative, but that it was actually achievable.

Because of the 2006 Massachusetts health reform legislation we have the highest rate of health care coverage in the nation—98 percent of our residents have health care coverage, including 99.8 percent of our children. That is something we can all take great pride in. So many critics said it just couldn’t be done.

Contrary to the partisan rhetoric that health reform would push everyone into public programs and erode private health insurance, employer-based coverage is growing in Massachusetts, even as it has declined in most states. In Massachusetts, 76 percent of employers now offer coverage; the national average is just 60 percent.

Health reform has improved access to care in Massachusetts. People are more likely to receive care, such as doctor visits, preventive care visits and dental care now than they did before health reform. In the last year, 84 percent of Massachusetts residents had at least one visit to a doctor, and 76 percent had a preventive care visit.

We have accomplished all of this while public support for Massachusetts health reform has grown from 53 percent in 2009 to 63 percent today.

Not only does Governor Patrick know how to effectively implement universal health coverage, he also keenly understands the interrelationship of federal health programs. Just as in national health reform, Medicaid represents the foundation of our state effort to expand health coverage.

Like a handful of other states, Massachusetts has already expanded our Medicaid program beyond federal requirements. The Affordable Care Act increases Medicaid eligibility for all non-elderly parents and childless adults, children, and pregnant women with income up to 133 percent of poverty. More than one in three uninsured Americans has income below the poverty level. Eroding Medicaid eligibility will increase the number of uninsured Americans and severely undermine national health reform.

House Budget Committee Chairman Ryan's budget slashes Medicaid by \$1.4 trillion over the next decade and converts it to a block grant. This budget proposal would result in a loss of more than \$23 billion in health benefits for Massachusetts residents and 540,000 could see their coverage cut entirely. Most of the savings from this proposal would come from shifting costs on to states, which will then cut benefit packages for poor seniors, people with disabilities and low-income children, cut already-low payments to providers, or both.

Chairman Ryan calls his budget the "Path to Prosperity", but that's not where its path would take our seniors. At least two-thirds of the over \$4 trillion in budget cuts come from programs serving those of modest means. To be clear, the House budget is not about reducing the debt. It is about putting in place Republican priorities – increasing tax cuts for the wealthy while slashing social programs.

Chairman Ryan also proposes to eliminate Medicare as we know it and replace it with a voucher paid directly to private insurance companies. The value of the voucher will be about \$8,000 on average and it's paid directly to private insurance companies. It will fail to keep pace with increases in the cost of health care so its value will decline every year, meaning that future seniors won't be able to get the benefits they need or even end up uninsured.

According to the nonpartisan Congressional Budget Office, Chairman Ryan's proposal would double health care costs for seniors as compared to the current Medicare system. In Massachusetts, over one million seniors and people with disabilities rely on Medicare for their health care coverage. The House plan means the average senior would have to pay \$6,000 more for Medicare in 2022 and \$11,000 more in 2030.

Their budget is not about controlling health care costs, it's about shifting the costs on to seniors, children, and those with the most vulnerable in our society. And it stands in stark contrast to the Affordable Care Act which put Medicare on the path to long-term savings by testing out the most promising models of payment reform that reward the quality of care delivered instead of the quantity of tests ordered and services performed.

Massachusetts is known for its revolutionary spirit, so it's no surprise that we paved the way for nation health reform. In our ongoing pursuit of cost containment, I'm convinced Massachusetts will once again lead the way.

Governor Patrick is proposing a host of reforms that would lower health care costs in Massachusetts by improving the quality of care and delivery of service. These reforms build off the proposals in the Affordable Care Act and represent the right approach to transforming health care delivery systems by reorienting payment incentives and bending the curve of growth in national health care spending.

I look forward to today's witness testimony and to having a much-needed factual discussion about the role of Medicare and Medicaid in federal deficit reduction.

Testimony of
Massachusetts Governor Deval L. Patrick
Before the
Senate Finance Committee
United States Congress, Washington, DC
Thursday, June 23, 2011

Chairman Baucus, Ranking Member Hatch and Members of the
Committee:

Thank you for the opportunity to appear before this Committee
to address the impact that proposed reforms of our health care
entitlement programs would have on the states and our citizens.

Reforming the Medicare and Medicaid programs to ensure their
long-term sustainability is a priority that I share with the members of
this Committee, with many other governors, and with the Obama
Administration. It's also a necessary element in the effort to reduce
the national budget deficit, a goal I believe is both important and
achievable. But how we reform these programs is about people, not

abstract policies. It's about what kind of country we want to live in, and what kind of future we are building for the next generation.

My comments come from that perspective because I do my job with that perspective. And although Medicaid is a small part of the medical cost picture, I want to focus my comments mainly on that.

Like nearly every state in the last few years, in Massachusetts we have had to make tough choices to manage through the global economic collapse. We have cut billions of dollars in spending and thousands of state jobs. We have imposed furloughs and pay freezes, and negotiated concessions from public employee unions. We have also prudently used our "rainy day" funds, modestly increased our sales tax,¹ and benefited, like every other state, from the support of the American Recovery and Reinvestment Act.²

We have at the same time invested significantly in education, health care and job creation -- because we all know that educating

¹ See www.massbudget.org/file_storage/documents/FactsSales.pdf.

² See http://articles.boston.com/2011-05-30/news/29600265_1_federal-stimulus-budget-debate-rainy-day-fund.

our kids, securing people's health care, and putting people to work is the best way to climb out of our economic hole and build a better future.

Because we made those choices, on both the spending and the revenue side, the Massachusetts economy is now growing twice as fast as the Nation's.³ Our unemployment rate, at 7.6%, is well below the national average and declining.⁴ Our annual budgets have been responsible, balanced and on time; our decades-long structural deficit has been eliminated; and our bond rating has not only remained strong, but gotten stronger.⁵ In fact, we are one of only three states in America whose fiscal outlook is currently positive.⁶

The Massachusetts experience may offer a lesson for the national discussion today. We were able to cut spending, reform

³ See U.S. Department of Commerce, Bureau of Economic Analysis, http://www.bea.gov/newsreleases/regional/gdp_state/gsp_highlights.pdf, (showing Massachusetts is the fourth fastest growing state economy). See also Boston Globe, "Mass. recovery leading region," June 8, 2011,

http://www.boston.com/business/articles/2011/06/08/mass_economys_growth_fourth_in_the_nation/.

⁴ Regional and State Employment and Unemployment Summary, Bureau of Labor Statistics, June 17, 2011, <http://www.bls.gov/news.release/laus.nr0.htm>.

⁵ See "FISCAL FALLOUT: The Great Recession, Policy Choices, and State Budget Cuts -- An Update for Fiscal Year 2012," MassBudget, April 3, 2011.

http://www.massbudget.org/documentsearch/findDocument?doc_id=781; Governor's Message, Fiscal Year 2012 Budget Proposal; January, 2011, http://www.mass.gov/bb/h1/fy12h1/msg_12/hdefault.htm.

⁶ Standard and Poor's "US States Ratings and Outlooks," May 12, 2011.

government and invest in a stronger future because we did not leave our values at the door, because we kept asking ourselves whether the choice before us moved us closer to the kind of community we wanted to be.

In that spirit, we have made a number of changes to enable us better to control costs in our Medicaid program. We are also working on an exciting strategy to reduce medical costs across the system, well beyond the Medicaid program, that will benefit all of our citizens, help our state's economy, and further improve our competitiveness. We have pursued these reforms and savings in the firm belief that health is a public good, and that everyone deserves access to quality care – including the poor and disabled.

Flexibility in the administration of the Medicaid program has made all the difference. So, first, like many of my fellow governors, I strongly support the states having the flexibility to innovate costs down. The current Medicaid program, as administered today, gives states precisely that: a high degree of flexibility to design a program that suits an individual state's needs.

Massachusetts has taken advantage of that and we have several innovative programs deployed right now that show a lot of promise.⁷ For example, “dual eligibles” – folks who fall under both Medicaid and Medicare -- account for 40 percent of Medicaid’s national spending even though they only make up 15 percent of its members.⁸ When you add in Medicare, spending on this group alone accounts nationally for over \$300 billion per year.⁹ Because of the regulatory maze in which these patients are treated and the complexity of their conditions, dual eligibles are a major cost driver in Massachusetts -- just as in the rest of the country.¹⁰

In partnership with the Obama administration and the Center for Medicare and Medicaid Innovation, we are creating a demonstration program that integrates the delivery of Medicare and Medicaid for dual eligibles, finding more cost effective pathways to get patients the

⁷ See Center for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office, http://www.cms.gov/medicare-medicaid-coordination/05_StateDesignContractSummaries.asp.

⁸ See Kaiser Family Foundation, “Dual Eligibles: Medicaid’s Role for Low-Income Medicare Beneficiaries,” May 2011, <http://www.kff.org/medicaid/upload/4091-08.pdf>; see also “Letter from Secretary Sebelius to the nation’s governors,” February 3, 2011, available at <http://www.hhs.gov/news/press/2011pres/01/20110203c.html>.

⁹ See *Dual Eligibles: Understanding This Vulnerable Population and How to Improve Their Care: Hearing before the H. Comm. on Energy and Commerce*, 111th Cong. 6-21 (2011) (Statement of Melanie Bella, Director of the Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services).

¹⁰ Kaiser Family Foundation, “Dual Eligibles: Medicaid’s Role for Low-Income Medicare Beneficiaries,” May 2011, http://www.cms.gov/medicare-medicaid-coordination/05_StateDesignContractSummaries.asp.

care they need. The preliminary analysis suggests this will lead to decreased emergency visits, fewer unnecessary hospitalizations, and better access to and use of appropriate medications. That will translate into real savings for both the state and federal sides of the Medicaid equation. Under this strategy, we estimate at least a 2 percent savings on the \$4 billion we expect to spend on “dual eligibles” in the first year of the program.

Other working models for addressing dual eligibles are already in use. New Mexico and Texas, for example, use managed care programs to bring better coordination to services. Enrollment plans like PACE and Special Needs Plans, currently being used in Massachusetts as well as in New York, New Mexico and Wisconsin, are further examples of states using the considerable existing administrative flexibility to achieve savings in the Medicaid program. Wider adoption by the states would help significantly curb Medicaid costs.¹¹

¹¹ See Center for Medicare and Medicaid Services, “Program of All Inclusive Care for the Elderly,” <https://www.cms.gov/PACE/LPPO/list.asp#TopOfPage>, and Center for Health Care Strategies, “States with Fully Integrated Care Programs for Dual Eligibles,” http://www.chcs.org/usr_doc/ICP_State-by-State_Dashboard.pdf.

Rising costs in the health care system across the Nation are a serious national problem.¹² In fact, Medicaid spending has been growing more slowly than the dramatic health care cost increases in the rest of the economy.¹³ For that reason, we have turned our attention there, to the broader question. Everyone has a stake in that solution. And just as Massachusetts is the home of the nation's most successful universal health care law, we are poised to crack the code on cost containment.¹⁴ To get there, we are doing more to encourage integrated, whole person care: paying providers for the quality of health care they deliver, not just the quantity. There are many good models being tried in the market today. We are working on scaling them up and making sure the savings are passed along to businesses, families and government in the form of lower premiums.

¹² See Demos Institute, "Understanding the National Deficit and Debt: A Primer," 2010, (noting that a primary cause of the country's long-term fiscal imbalance is the rapidly rising cost of healthcare. The United States already spends nearly twice as much on healthcare, as share of GDP, as most of its international peers.) <http://demos.org/afc/deficit101Final.pdf>.

¹³ According to the Center for Medicare and Medicaid Services, between 2000 and 2008, Medicaid per capita spending for covered families increased by an average of only 5.2% per year, compared to 7.2% in the private sector. http://www.kff.org/pullingittogether/021610_altman.cfm. The same is true in Massachusetts, where private insurance spending per member year increased 5.7% from 2007-2008, while comparable Medicaid spending increased only 2.8% over the same period for MassHealth, Massachusetts' Medicaid program. "Massachusetts Health Care Cost Trends," Division of Health Care Finance and Policy. June 2011.

<http://www.mass.gov/?pageID=eohhs2subtopic&L=6&L0=Home&L1=Researcher&L2=Physical+Health+and+Treatment&L3=Health+Care+Delivery+System&L4=Health+Care+Cost+Trends&L5=2011+Health+Care+Cost+Trends&sid=Eeohhs2>.

¹⁴ See Boston Globe Editorial, "To contain health costs, state should try a new way of paying," January 2, 2011, http://articles.boston.com/2011-01-02/bostonglobe/29346007_1_current-fee-for-service-system-health-care-health-insurance.

Medicaid currently allows us this flexibility. We need the Congress to encourage more states to take advantage of that flexibility, and embrace our role as policy laboratories -- not just around entitlements, but in health care spending generally. That is the larger policy challenge we face as a Nation. Fix that, and not only do the Medicaid and Medicare programs become fiscally sustainable, but the prospects for a strong, sustained economic recovery improve dramatically.

Second, let's stick with what works. The Affordable Care Act works. We know from experience with our own health care reform measure that getting people insured and having them receive their care in primary care settings as opposed to emergency rooms is cost effective¹⁵ and will reduce illness and death.¹⁶ According to the Congressional Budget Office, the Affordable Care Act will reduce the deficit by \$124 billion through 2019 and by more than \$1 trillion in the

¹⁵ See Massachusetts Taxpayers Foundation, "Massachusetts Health Reform: The Myth of Uncontrollable Costs," May 2009, (noting that Massachusetts broke new ground with its approach to health care reform, and thus far the underlying financial model of shared participation is working well, with major strides in reducing the size of the uninsured population and only a marginal impact on state spending.) http://www.masstaxpayers.org/publications/health_care/20090501/massachusetts_health_reform_the_myth_uncontrollable_costs.

¹⁶ See <http://www.urban.org/publications/411588.html> (reporting that 137,000 people died from 2000 through 2006 because they lacked health insurance, including 22,000 people in 2006).

subsequent decade.¹⁷ Indeed, the ACA provides for even more Medicaid and Medicare flexibility than under current law. Efforts to repeal it take us in exactly the opposite direction from fiscal responsibility.

Third, put revenues on the table. Our federal government has been running two wars and a costly prescription drug benefit for nearly a decade with borrowed money.¹⁸ Meanwhile, thousands of industries and special constituencies -- from oil to agriculture -- find favorable treatment and loopholes in our tax code.¹⁹ I know small “mom and pop” stores and college students who pay more taxes than global companies with billions in revenue. Some of these loopholes ought to be closed. If we believe that even the poor and disabled -- the people Medicaid serves -- should get adequate health care, it is only fair to ask everyone to help close a gap other policy choices

¹⁷ Congressional Budget Office, “CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010,” May 30, 2011, <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>.

¹⁸ Kathy Ruffing & James R. Horney, *Economic Downturn and Bush Policies Continue to Drive Large Projected Deficits*, CBPP, May 10, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3490>; Marc Labonte & Andrew Hanna, Cong. Research Serv., R41134, *The Impacts of Major Legislation on Budget Deficits: 2001 to 2009* (2010), <http://www.fas.org/spp/crs/misc/R41134.pdf>.

¹⁹ See, e.g., *Analysis: 12 Corporations Pay Effective Tax Rate of Negative 1.5% on \$171 Billion in Profits; Reap \$62.4 Billion in Tax Subsidies*, CTJ, June 1, 2011, <http://www.ctj.org/pdf/12corps060111.pdf>.

have created. We cannot and should not get out of the deficit hole with spending cuts alone.

Finally, I wish to respectfully object to the budget proposal that has come out of the House. That proposal represents a radically different set of values. It embraces a voucher program that effectively ends Medicare, and replaces it with minimal coverage security for seniors and the disabled. It would put Medicaid on a path to denying coverage to millions of the poor.²⁰ It would repeal the Affordable Care Act, denying coverage to millions of working American families. Yet it includes \$1.1 trillion in tax benefits for the wealthy, benefits they have not asked for and which recent history shows have not been effective in spurring economic growth.²¹

²⁰ See "Ryan Medicaid Block Grant Would Cause Severe Reductions in Health Care and Long-Term Care for Seniors, People with Disabilities, and Children," Center on Budget and Policy Priorities, May 3, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3483>.

²¹ See e.g. William G. Gale & Benjamin H. Harris, *Reforming Taxes and Raising Revenue: Part of the Fiscal Solution*, Tax Policy Center, May, 2011, <http://www.taxpolicycenter.org/uploadedpdf/1001539-Reforming-Taxes-Raising-Revenue.pdf>; Michael Linden & Michael Ettlinger, *Three Good Reasons to Let the High-End Bush Tax Cuts Disappear This Year*, Center for American Progress, July 29, 2010, http://www.americanprogress.org/issues/2010/07/let_cuts_expire.html; *Tax Cuts: Myths and Realities*, CBPP, May, 9, 2008, <http://www.cbpp.org/files/9-27-06tax.pdf>; Jason Furman, *Treasury Dynamic Scoring Analysis Refutes Claims by Supporters of the Tax Cuts*, CBPP, Aug. 24, 2006, <http://www.cbpp.org/files/7-27-06tax.pdf>.

Ultimately that is a vision for the future of our country that retreats from our values as Americans. It is about abstract policy or politics. But our job as leaders is to be about people.

Dispersing federal Medicaid funding in the form of block grants, as some have proposed, won't reform the system. It will starve it. By failing to account for changes over time in a state's economic needs or demographics, or innovations in how health care is delivered, the proposed block grants lock states into a fiscal bind that forces us to deny coverage or make other changes to services. It passes a burden from the federal government to the state level, knowing that states cannot carry the load. Block granting Medicaid would constitute nothing more than an accounting device for the federal budget, while dealing a crushing fiscal blow to states that are already struggling.

This latter point cannot be overstated. Right now 33 states are projecting a cumulative budget gap of \$75.1 billion or more in Fiscal

Year 2012.²² The Kaiser Family Foundation estimated that Massachusetts would lose more than \$23 billion over ten years if Medicaid moves to a block grant formula.²³ By 2021, this could mean denying close to 540,000 residents of the Commonwealth of their health care coverage.²⁴ And the payment model that compensates hospitals for care would be gutted by more than 30% in the same period.²⁵ In a state where 98% of our residents currently have access to health care, well ahead of other states, this would be a public health catastrophe and an utter failure of leadership.²⁶ There is no way the Commonwealth would be able to absorb such a shift without seriously curtailing critical programs and services, including the most successful experiment in America in universal health care. And it would cost tens of thousands of jobs. Asking states to pick up more of the tab in a time of unprecedented fiscal challenges is unrealistic as well as unwise.

²² National Governors Association, "Fiscal Survey of States," Spring 2011, <http://www.nga.org/Files/pdf/FSS1106.PDF>.

²³ Kaiser Family Foundation, "House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing," May 2011, <http://www.kff.org/medicaid/upload/8185.pdf>.

²⁴ *Id.*

²⁵ *Id.*

²⁶ See Office of the Governor, Commonwealth of Massachusetts, December 13, 2010, http://www.mass.gov/?pageID=gov3pressrelease&L=1&L0=Home&sid=Agov3&b=pressrelease&f=101213_health_care_report&csid=Agov3.

Some states advocate for block granting in the name of “flexibility” or repealing the Affordable Care Act as “the first step for a successful Medicaid transformation,” as 29 Republican governors propose in a recent letter to Congressional leaders.²⁷ But the data suggest that doing either is really a formula for limiting coverage, not sustaining the program. For states to sustain current eligibility for the Medicaid program, under these governors’ proposal, would require states to spend approximately \$241 billion, or 71% more than current levels over the next ten years.²⁸ No state is fiscally prepared to deal with that. Tactics like these will reduce the federal deficit on paper -- on the backs of the working families and small businesses who are making our economic recovery possible.

Medicare and Medicaid have helped generations of Americans help themselves. They are commitments that the federal government has made to the American people and they have contributed mightily to the economic prosperity and success that our Nation has enjoyed.

²⁷ “Republican Medicaid Reform Principles,” Republican Governors’ Association, June 13, 2011, <http://www.rga.org/homepage/gop-govs-unveil-medicaid-reform-principles/>.

²⁸ Kaiser Family Foundation, “House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing,” May 2011, <http://www.kff.org/medicaid/upload/8185-S.pdf>.

Our challenge today is to modernize and refine these commitments, not to squeeze them out of existence with accounting tricks and political rhetoric. The strategies being proposed from some corners will not lead to better Medicare or Medicaid, but will simply mean less Medicare and Medicaid.

Working together we can meet our obligations to our most vulnerable citizens, put America on a fiscally sustainable path and build a better, stronger Nation for the next generation. That is the responsibility with which our constituents have entrusted each of us and I look forward to working with you and your colleagues to fulfill that obligation.

Thank you again for inviting me here today and I look forward to taking your questions.

STATEMENT ON MEDICARE 'REFORM'
by
Bruce C. Vladeck, Ph.D.

Before the Hearing on
"Health Care Entitlements: The Road Forward"

Committee on Finance
United States Senate
June 23, 2011

Mr. Chairman, Senator Hatch, Members of the Committee, it is a great pleasure and honor to have the opportunity to appear before you today. I am Bruce C. Vladeck, Senior Advisor to Nexera, a consulting subsidiary of The Greater New York Hospital Association. I am also Chairman of the Board of the Medicare Rights Center, and a Trustee of Ascension Health. The views I express today are solely my own and not necessarily those of any of those organizations.

Mr. Chairman, it has been 14 or 15 years since I last sat at this table, in a rather different role, and while much has obviously changed since then, I confess to a very strong sense of déjà vu this morning. In 1996 and 1997 – and then through 1999, when I served as a member of the National Bipartisan Commission on the Future of Medicare – there was a putative “crisis” in Medicare that was considered central to any plan to reduce a serious federal budget deficit. The Hospital Insurance Trust Fund faced looming insolvency, and the projected growth rate of Medicare expenditures was forecast to crowd out other discretionary expenditures and make deficit reduction unattainable. The growth in Medicare expenditures was widely characterized as “unsustainable.”

The Congress took action in 1997, as it had many times before in the history of the Social Security Act, and by 1999 the federal budget was in surplus. The expected life of the Hospital Insurance Trust Fund was extended by twelve years, and in calendar year 1998 total Medicare outlays actually went down compared to the prior year. The Balanced Budget Act (BBA) kept Medicare on a sound financial footing for another 10 to 15 years. There’s no reason we can’t do that again, just as we did in 1972, 1982 and 1983. In short, while the Medicare program has long-term financial problems that must be addressed, as I will discuss, the current so-called “crisis” is in fact an artifact of broader problems with the federal budget and budgetary politics, and should not be used as an excuse to dismantle one of the most important programs the federal government has ever operated, or to renege on the commitment this government has made to generations of working people as it has collected taxes from them.

In that context, I’ve organized the balance of my remarks today into three sections. First, I will speak very briefly about the relationship between Medicare’s finances and broader economic trends. Second, I will take note of some recent developments in Medicare’s evolution and show how they connect to alternative approaches to Medicare’s finances. All roads lead, I believe, to the much more fundamental problem of health care costs and how their growth can be decelerated, and discussion of that subject will conclude my written remarks.

The Two Sides of Medicare Solvency

The Congressional Budget Office (CBO) originally estimated that the BBA would extend the life of the Hospital Insurance Trust Fund by 10 years, to 2008, but by 2001 the estimated exhaustion date for the Fund had been moved outward another 21 years, to 2029. No significant Medicare

policy changes were enacted during that period, although the CBO had corrected its wildly inaccurate projections of the BBA's budgetary effects. Instead, what changed was that the economy grew much more rapidly than CBO or the Office of Management and Budget or anyone else had expected. More recently, the 2011 Report of the Medicare Trustees reduced the Trust Fund's expected years of remaining solvency, again not because of any policy changes or any radical surprises in Medicare's rate of expenditures, but because the nation's economy has emerged much more slowly than expected from the effects of the recession that began in 2008. All of that is a useful reminder that the actuarial balance of Medicare (whether in the Trust Funds or through general revenue) is affected by two phenomena. We tend to focus most of our attention on the program's outlays, but the other half of the equation is income. And income is determined by the level of economic growth and by tax rates.

The most important thing that can be done to improve Medicare's long-term fiscal outlook (and, for that matter, Social Security's), is to get the economy growing again. I know how obvious that sounds, but since we health policy wonks often seem oblivious to what's going on in the rest of the economy, I believe it's an essential reminder. It's worth repeating that the percentage of gross domestic product (GDP) accounted for by Medicare, or more relevantly by all health care expenditures, depends just as much on how big GDP is as on how much health care costs. At the same time, as the number of Medicare beneficiaries roughly doubles over the next 25 years, unless we are far more successful at reining in cost growth than anyone has predicted might seem possible, we are going to have to add some money to the program, either from general revenues or, I would prefer, a more progressive revenue source.

Approaches to "Reform"

The relationship between outlays and revenues hasn't changed since 1997, but much else has:

- Out-of-pocket costs for Medicare beneficiaries, largely in the form of soaring premiums, have skyrocketed, while incomes of seniors (like those of most Americans except the wealthiest) have stagnated;
- At the same time, the proportion of working people with employer-provided retirement health benefits that supplement basic Medicare coverage has plummeted, and is likely to effectively disappear altogether in the foreseeable future, meaning that future generations of Medicare beneficiaries will have even less protection against out-of-pocket costs than current beneficiaries.
- A prescription drug benefit was added to the Medicare program. While Part D is more expensive and cumbersome, and imposes greater burdens on beneficiaries than might have been necessary, it has unquestionably brought significant help to millions of Americans. But it was enacted without any specific financing

mechanism other than the shares accounted for by beneficiary premiums and State contributions, and has contributed materially to the expected long-term growth in Medicare's general revenue expenditures.

- As has always been anticipated, the number of Medicare beneficiaries has continued to grow at a pace that will accelerate as we "baby boomers" increasingly reach retirement age;
- Overall health care costs have continued to grow substantially faster than the rest of the economy;
- Because private sector costs have grown more substantially than Medicare's costs each of the last 15 years, the difference in payment rates between Medicare and private insurers for hospital and physician services has widened considerably. As Medicare patients comprise an ever larger share of all hospital patients, this puts increasing financial pressure on hospitals in rural areas and less-affluent urban communities;
- and, of course, The Affordable Care Act (ACA) was enacted in 2010, which not only significantly strengthened Medicare's finances, but also laid out a number of mechanisms designed to encourage greater effectiveness and efficiency in the health care system.

In other words, despite all these significant developments, what was true about Medicare during the deliberations of the National Bipartisan Commission remains just as true today:

- Even with the addition of the prescription drug benefit and expanded coverage for certain preventive services, the Medicare benefit package remains woefully inadequate. On average, Medicare pays less than half the health care costs of its beneficiaries. In the terminology of the ACA, this would not even qualify as "Bronze" coverage, even though Medicare beneficiaries have the highest burden of illness of any demographic group in the insurance market.
- Partially as a result of the benefit structure, as a share of their incomes Medicare beneficiaries pay three times as much out-of-pocket as the privately insured, although their income is, on average, only half as great.
- There remain significant opportunities for savings in the Medicare program – in the prices Medicare pays, for example, for durable medical equipment, clinical laboratory services, and prescription drugs – that the Congress continues to ignore or reject.

In other words, the traditional knee-jerk approaches to reducing health insurance expenditures are especially inappropriate for Medicare. Not only shouldn't we reduce benefits from their already minimal levels; when budgetary circumstances are more favorable we should significantly *improve* them. Out-of-pocket costs for Medicare beneficiaries already exceed any conceivable threshold at which behavior might have been altered, and a growing body of data makes clear that increased out-of-pocket expenditures at the point of service are as likely to deter clinically

necessary utilization, with serious health consequences, as less necessary utilization. We could continue to raise the costs of Medicare for upper-income beneficiaries, but we've done that twice already, in 1997 and 2010, without major effects on Medicare's overall financial health. We could increase the age of eligibility for Medicare as the ACA takes effect, but doing so would achieve savings for the government largely by shifting the costs to beneficiaries and employers. And if we increase the eligibility age and repeal the ACA in total or in part, millions of especially vulnerable citizens will be left uninsured and uninsurable.

There's really only one way out: In order to keep the promise of Medicare – affordable access to mainstream medical care for older and disabled Americans - without any further hollowing-out of what that promise contains, we have to achieve substantial reductions in the rate of growth of health care costs. Of course, we also have to achieve substantial reductions in the rate of growth of health care costs in order to move towards coverage for all Americans, avoid ruin for American businesses large and small, and avoid a more general economic catastrophe.

Addressing Health Care Costs

In talking about health care costs, it's first essential to distinguish between approaches that actually get to the costs of producing and obtaining health care from those that merely limit the federal government's costs by shifting them on to sick people. Proposals such as that adopted by the House Budget Committee, for example, effectively cap the government's liabilities, but they do so primarily by shifting costs to beneficiaries who, despite a lifetime of payroll tax contributions, are already paying more for their health care than other Americans. More sophisticated proposals like "premium support" are fundamentally the same wolves dressed up in fancier clothing. We have 25 years of empirical experience that consistently confirms the point that private plans simply cannot deliver a defined package of health insurance benefits less expensively than Medicare does. In terms of dollars spent for services actually provided, the only health insurance program in the United States less expensive than Medicare is Medicaid. Creating a voucher with which to purchase private plans while saving the federal government money will therefore inevitably increase costs to beneficiaries, or reduce the value of the benefits they receive, or – most likely – both.

The alternative approach to controlling the growth in health care costs is more difficult, more complex, and more frustrating – as well as more likely to gore the oxen of particular private interests. It's no wonder that pundits and politicians shy away from them. But there really isn't a defensible alternative. We need to get to work.

We need to encourage changes in our delivery system that increase efficiency, reduce waste, increase patient satisfaction, and improve outcomes. We also need to find better ways to pay for health services – whether the payer is public or private. None of this is easy to do. But the

Congress, and especially this Committee in its work on the ACA, laid out a multi-pronged effort to systematically test and evaluate almost every approach anyone could think of – and, through the Center for Medicare and Medicaid Innovations (CMMI), some that haven't yet been even thought of. In many instances, these provisions of the ACA focus on efforts not confined to Medicare itself, but capable of engaging and encouraging parallel efforts by private insurers, to achieve a wider impact on health care costs. Personally, I'm skeptical about a number of the approaches promoted by the ACA, but we don't have to bat 1.000, or anywhere close, to identify things that will really work.

For example, demonstration projects that share cost savings between hospitals and physicians at Beth Israel Hospital in New York and twelve hospitals in New Jersey are already producing significant cost reductions and improved quality of care. Medicaid Health Homes demonstrations by testing better ways of managing care for individuals with complex chronic illnesses, may well point the way for similar arrangements for Medicare patients. And for the first time since the adoption of the PACE benefit in the BBA, we are seeing widespread planned experimentation in delivery models for chronically ill dually-eligible Medicare/Medicaid beneficiaries. This is hardly a complete list, and this entire effort is a work in progress – now just at its earliest stages. But it's the most systematic effort of its sort in the history of American health care.

And if all these efforts to encourage appropriate changes in health care delivery and health care payment mechanisms fail to stanch the flow of health care inflation, the inevitable fallback is reductions in payment rates to providers. I personally have some serious reservations, on both administrative and policy grounds, about the Independent Payment Advisory Board (IPAB), but the BBA and literally dozens of other federal and state policy changes over many years make several things clear:

- You can save money, both in the short term and permanently, by reducing payment rates to providers and plans;
- Under the appropriate circumstances, carefully-designed payment reductions can reduce outlays without affecting access to care or negatively affecting quality. Indeed, sometimes they can lead to significantly increased quality. But the risks are real, so the process requires careful deliberation, sophisticated analysis, and open, participative decision-making. How to achieve such a process is, of course, the very issue with which you are now grappling relative to the future of IPAB.
- The organizations whose payment rates are reduced are going to be very mad at their elected representatives.

In other words, as a last resort in the event that delivery system reform doesn't save enough money, preserving the Medicare benefit will require payment rate reductions. That should be a major incentive for the provider community to achieve savings before we get to that point, and

for elected officials to energetically encourage them. But if reform fails to meet its savings targets, someone is going to have to take the heat for payment reductions.

In deference to the Committee's constraints, this has obviously been a very condensed review of a number of important topics. I'd be delighted to respond to any questions anyone might have.

Once again, I am honored by the opportunity to appear before you today, and I thank you very much for the privilege and for your attention.

COMMUNICATIONS



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**Statement
of the
American Hospital Association
before the
United States Senate Committee on Finance**

“Health Care Entitlements: The Road Forward”

June 23, 2011

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on various deficit reduction proposals and their impact on health care entitlement programs and patient access to care.

America’s hospitals both understand that our nation is facing a serious fiscal crisis, and that action must be taken both to raise the debt limit and control government spending. Given that Medicare and Medicaid comprise more than 20 percent of all federal spending — and, on average, around 55 percent of hospital revenues — cuts to either or both programs would have large implications for the country, the hospital field and the patients and communities we serve.

Below you will find a brief summary of several deficit-cutting proposals that would significantly impact health care entitlement programs.

PROPOSALS UNDER CONSIDERATION

President Obama has appointed Vice President Biden to lead a group of bipartisan legislators from the House and Senate to develop a deficit reduction package that could be passed as part of the vote on a debt-limit extension. While we do not yet know what plan will result from those discussions, several proposals to address the debt limit/deficit challenge have emerged that provide a menu of options from which negotiators could select. Our thoughts on several of the major proposals put forward thus far follow.

The Commitment to American Prosperity (CAP) Act: This legislation would limit federal spending to 20.6 percent of the Gross Domestic Product (GDP) by 2023. Currently, federal spending represents approximately 24 percent of GDP. Annual spending targets would be established, and automatic cuts (“sequesters”) would be implemented if Congress failed to legislate changes to achieve the targets. Increased revenues are not included as an option to achieve the budget targets. This approach could result in enormous cuts to both Medicare and Medicaid.

The AHA, AARP, American Medical Association, American College of Cardiology and LeadingAge commissioned a study to understand the real-world impact such across-the-board spending cuts in federal programs could have on some of our nation’s most vulnerable, including the elderly, children and low-income families. The study, conducted by The Lewin Group, found that under the CAP Act proposal by 2021:

- 5.1 million individuals would lose their health insurance.
- Cuts to hospitals would force most to operate in the red, jeopardizing access to care.
- Dramatic reductions in fees for physician services could lead to fewer physicians participating in Medicare.
- Up to 1.3 million health care workers could lose their jobs.
- Social Security benefits would be cut by nearly 20 percent.
- Cuts to Social Security and other income support programs would force 3.8 million people into poverty – 2.1 million of them seniors, a 45 percent increase.
- Cost shifting of federal payment shortfalls to private employers could lead to a nearly 5 percent increase in health insurance premiums.

While the CAP Act may not be included in the final agreement, similar consequences could result from any across-the-board measure that sets specific limits on spending. The AHA opposes any such arbitrary caps or triggers.

House Budget Resolution: Authored by House Budget Committee Chairman Paul Ryan (R-WI), the resolution, which has passed the House of Representatives, would cut Medicaid by \$771 billion over 10 years. We are extremely concerned about further reductions to Medicaid, especially as many states continue to make significant cuts to the program as they struggle to balance their budgets. This proposal could severely impact access to care for our most vulnerable patients.

The proposal also rolls back expansions of health coverage to millions of people but keeps the \$155 billion in reductions to hospitals contained in the health reform law. Hospitals provide nearly \$40 billion in uncompensated care per year, and that number will grow if coverage is not expanded to those who cannot afford care.

President's Commission on Fiscal Responsibility's Proposal: This bipartisan commission appointed by the president recommended a variety of Medicare budget cuts that impact hospitals, such as reducing payment for graduate medical education and bad debt. These recommendations would reduce Medicare funding by about \$100 billion to hospitals over 10 years. In addition, they recommend the elimination of the use of Medicaid provider assessments (which would save \$44 billion over 10 years), and an expansion of the Independent Payment Advisory Board (IPAB).

The commission's IPAB recommendation removes lawmakers from decisions that will affect health care in their community. The proposal also calls for reductions in federal spending on graduate and indirect medical education at a time when physicians are in short supply. In addition, the report calls for cutting the Medicare bad-debt program, which provides funding to hospitals that treat seniors who are unable to pay their bills.

While the recommendations make some positive movement in liability reform, we are disappointed that caps on non-economic damages were not included. The elimination or scaling back of provider assessments in the Medicaid program will remove crucial funding for states already under significant budget pressures. And while we are supportive of testing delivery systems reforms such as accountable care organizations (ACOs) and bundling, these are untested ideas that should not be broadly implemented, as the commission suggests, until significant evaluation occurs, and legal and regulatory barriers that impede collaboration between hospitals and physicians are eliminated. We also have concerns that the

recommendation to cap national health expenditures does not take into account the aging population and the demand for services.

President Obama's Proposal: The president's initial budget for fiscal year (FY) 2012 included more than \$60 billion in Medicaid reductions. The most significant proposal impacting hospitals would limit to 3.5 percent the amount that any sector may be taxed under Medicaid provider assessment programs. This would achieve savings of approximately \$18 billion over 10 years.

In addition, the president proposes two enforcement mechanisms to reduce spending. First, the president's plan would limit Medicare spending to GDP plus 1 percent from 2014 to 2017, then GDP plus 0.05 percent in 2018 and beyond. Should Medicare spending exceed these amounts, IPAB would be given the authority to make recommendations to reduce Medicare spending. Such recommendations would receive fast-track consideration by Congress. Consistent with the *Patient Protection and Affordable Care Act* (ACA), hospitals would be excluded from these reductions through 2019. Along with the president's other recommended health care changes, this approach is estimated to save \$480 billion over 12 years. Second, the president's deficit reduction recommendations also would reduce the size of the overall federal deficit to a percentage of the GDP from approximately 10 percent currently to 2.8 percent over 12 years, and use automatic cuts (or sequesters) to enforce these limits starting in 2014. While Medicare and Medicaid provider payments are subject to sequesters, direct cuts to beneficiaries would be prohibited. In addition, increased revenues are a part of this mechanism.

America's hospitals also are concerned with the president's proposal to reduce provider assessments, which are used by most states to help finance their Medicaid programs. Curtailing this option will result in less funding and more pressure to cut Medicaid, jeopardizing services to the poor and the disabled.

We also are troubled that formula-driven, arbitrary budget targets could result in across-the-board cuts to health care. We will continue to oppose the use of this trigger that could impede patients' access to care and further exacerbate the "cost-shift," which would increase health care costs to employers and other purchasers of private coverage.

The president also expands the role of IPAB. America's hospitals support the repeal of IPAB, because its existence permanently removes Congress from the decision-making process, and threatens the important dialogue between hospitals and their elected officials about the real health care needs of their communities. Expanding IPAB adds to that problem.

THE HOSPITAL FIELD'S PRINCIPLES

The deficit-reduction plans offered thus far fail to consider an important reality: America's hospitals already are absorbing \$155 billion in payment reductions. And every single day, Medicare and Medicaid pay hospitals less than the cost of providing care. Hospitals provide critical services that no one else can. Yet hospital care is once again jeopardized by new and serious threats. Any additional cuts to hospitals could negatively impact patient care: services eliminated; longer waits for care; emergency departments shut down; and staffing reduced.

The field already is absorbing \$155 billion in reductions, as well as state Medicaid cuts. And, that does not include additional cuts imposed by regulation, such as coding offsets under the Medicare inpatient prospective payment system. America's hospitals know what it means to be part of shared sacrifice to achieve national goals. Therefore, we strongly oppose efforts to further cut payments for hospital services under Medicare and Medicaid. It's time that every other sector of society be held to the same level of shared sacrifice – examination and scrutiny – as we have been. We urge lawmakers to look outside both the hospital and health care sector for new ideas that could achieve budget savings.

Federal programs already underpay hospitals. Hospitals have made great progress in controlling costs and improving quality and are investing significant resources in health information technology to improve care even further. But we cannot continue this trend and absorb further cuts to federal programs, which already pay less than the costs of providing services.

Arbitrary triggers are not the answer. Hospitals are wary that formula-driven, arbitrary budget targets, such as the ones outlined in several proposals listed above, would result in across-the-board cuts to health care. We oppose the use of a trigger that could impede patients' access to care and further exacerbate the "cost-shift," which would increase health care costs to employers and other purchasers of private coverage.

Protect the safety net. Medicaid has been dramatically cut as states struggle to balance their budgets. Further cuts, such as the ones proposed in the House budget plan, would threaten this program, which is a lifeline to so many Americans. There are alternatives to these Medicaid cuts, such as:

- Applying ACA models like ACOs, bundling, medical homes and pay for performance to Medicaid;
- Coordinating care for dual eligibles and those with chronic conditions;

- Increasing the use of generic drugs;
- Restructuring copayments; and
- Designing tax incentives for long-term care.

Other Medicare alternatives also exist. Hospitals will continue to be part of the dialogue to offer solutions and support real reforms. This must be accomplished in a balanced way that considers concrete alternatives, such as:

- Creating a better alternative to our current liability system;
- Junk food taxes;
- Increased Medicare beneficiary cost-sharing;
- A tax cap on employer-provided health insurance benefits; and
- Adjusting the Medicare eligibility age.

SUMMARY

Thank you for the opportunity to share our concerns with the committee. America's hospitals know there are no easy solutions to get our fiscal house in order, and we will continue to be part of the dialogue to offer solutions that will benefit the patients and communities hospitals serve. We commend the committee for its contribution to the debate.

Comments for the Record

Health Care Entitlements: The Road Forward

United States Senate Committee on Finance

Thursday, June 23, 2011, 10:00 AM

215 Dirksen Senate Office Building

Submitted by:

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Chairman Baucus and Ranking Member Hatch, thank you for this opportunity to provide comments to the Committee. Now that we have been informed by the Trustees Report, it is up to the Congress and the advocacy community to map out the road forward. There are many issues which need to be addressed, with possible solutions inherent in each. We will address the impact of the *Affordable Care Act (ACA)*, the impact of premiums and co-pays, the possibilities of tax reform and the funding of Medicaid.

Health Care Reform

While the Trustees must offer their projections under law, the real story on what will happen in the future has yet to be written. The entire debate on cost shifting is premature until the impact of pre-existing condition reforms on the market is known. The issue that no one is talking about the likelihood that the mandates under the *ACA* may be inadequate to keep people from dropping insurance - and will certainly not work if the mandate is rejected altogether (which is now Dogma in the GOP).

If people start dropping insurance until they get sick – which is rational given the weakness of mandates – then private health insurance will require a bailout into an effective single payer system. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions while repealing mandates and pre-existing condition reforms.

In the event that Congress does nothing and private sector health insurance is lost, the prospects for premium support to replace the current Medicare program is lost as well. Premium support also will not work if the *ACA* is repealed, since without the *ACA*, pre-existing condition protections and insurance exchanges eliminate the guarantee to seniors necessary for reform to succeed. Meanwhile, under a public option without pre-existing condition reforms, because seniors would be in the group of those who could not normally get insurance in the private

market, the premium support solution would ultimately do nothing to fix Medicare's funding problem.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding). This will be discussed below.

Premium and COLA Reform

Bruce Bartlett wrote in the ~~New~~ **New York Times** Economix Blog on May 17 on the nature of the Medicare financial problem and how to fix it. The information he imparted is invaluable, however I disagree with his solution, which is to stop doing the Doc Fix. He relates that the ACA expansion of funding brought the Hospital Insurance Trust Fund (Part A) into balance, with parts B (doctor visits) and D (Drug coverage) responsible for most of the unsustainable cost growth, as patient premiums have declined from 50% of spending to 25% and with Drug coverage not at all close to covering program costs. (The CBPP states that premiums were always 25%, though if true, they are inadequate to control cost).

Stopping doctor bills from going up on the demand side will not work. We know that because it did not work for Medicaid - since restricting payments have stopped most doctors from taking Medicaid). This finding has a great deal of impact on what is possible in preventing the doctor fix.

The problem with Medicare Part B is that increases cannot keep up with costs, like they do in the private market, because doing so violates the commitment to not cut Social Security benefit checks. The cost of living adjustment must be high enough to cover the premium increase each year - although for many that is all it does. Further cuts bring up the specter of seniors eating cat food to make ends meet, hence the reason that the Fiscal Commission was called the Cat Food Commission by progressives.

Premium support and not patching doctor fees are attempts to make doctors restrict their costs - both to seniors and overall. Prices naturally rise more quickly than inflation because these services are subsidized, so any co-pay must be increased to slow demand from users in exactly the same way the market would without subsidies or insurance. The desire to make doctors pay more is a recognition that the main impact of both insurance and subsidies (and subsidies for insurance) is higher income for doctors and a larger medical care sector than would otherwise occur in a free market.

Our hybrid system is the most expensive option - either going to much less comprehensive insurance for everyone or an entirely governmental system would be cheaper, but is politically untenable (at least until private insurance collapses or is eventually supplanted by an ever expanding public option).

Going after doctors still won't work, however, as the Medicaid experience clearly shows. Premium support is a way to have insurance companies go after doctors instead, but that will likely yield the same result. Shifting the financial obligation to employers and past employers as part of a Net Business Receipts Tax would likely control doctor fees, although such a proposal will face resistance from both the medical and insurance sectors, even though it is the most likely to save money. Even if such a program is adopted, some employers are too small to support a

medical staff or support retiree health care, so some kind of public program is still necessary, with reform all the more crucial.

Making patients more conscious of their care might do the trick, both with more realistic premiums for Part B and Part D, with both rising to absorb half the cost - although premiums could be lowered by increasing co-pays and providing seniors with Flexible Spending and/or health savings accounts. The problem is that this is untenable when dealing with a population with largely fixed incomes. That problem, however, is not unsolvable.

The obvious solution, which no one has yet suggested, is to change how COLAs are calculated, moving from the wage index to an index based on what seniors actually buy - especially health care. If premiums were increased quickly, COLA changes would have to be as rapid.

Such a proposal would hasten the date that the Old Age and Survivors Insurance fund needs rescue. It also impacts lower income seniors to a greater extent than higher income seniors, since they have less left over after any mandatory co-pay. Either bend points would have to be reset or the entire complicated system of bend points would have to be replaced a new method of crediting contributions, where employer contributions are credited equally rather than as a match to the employee contribution - thus moving redistribution from the benefits side to the revenue side.

An average employer contribution would provide even more incentive for increasing the amount of income subject to benefits - or even eliminating the cap altogether. Of course, if you do the latter, we might as well simply use a Net Business Receipts Tax or a VAT to replace the employer contribution (which captures all income with the latter burdening imports as well)

Tax Reform

The committee well understands the ins and outs of increasing the payroll tax, so I will confine my remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical. Unlike a VAT, and NBRT would not be visible on receipts and should not be zero rated at the border - nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal - covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The Child Tax Credit should be made fully refundable and should be expanded to include revenue now collected under the dependent exemption, the home mortgage interest deduction and the property tax deduction. Transitioning these deductions will allow a \$500 per month per child distribution with payroll. It will likely increase incentives to expand affordable housing

and may not decrease housing for the wealthy, who are less likely to forgo vacation housing or purchase of luxury housing for want of a tax cut, as the richest families likely pay the alternative minimum tax anyway, so that they do not fully use this tax benefit now.

This tax should fund services to families, including education at all levels, mental health care, disability benefits, Temporary Aid to Needy Families, Supplemental Nutrition Assistance, Medicare and Medicaid. If society acts compassionately to prisoners and shifts from punishment to treatment for mentally ill and addicted offenders, funding for these services would be from the NBRT rather than the VAT.

This tax could also be used to shift governmental spending from public agencies to private providers without any involvement by the government – especially if the several states adopted an identical tax structure. Either employers as donors or workers as recipients could designate that revenues that would otherwise be collected for public schools would instead fund the public or private school of their choice. Private mental health providers could be preferred on the same basis over public mental health institutions.

If cost savings under and NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but not so much that the free market is destroyed.

This proposal is probably the most promising way to decrease 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. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Conceivably, NBRT offsets could exceed revenue. In this case, employers would receive a VAT credit.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets. Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a “balanced budget” rate. It could be set lower if the spending categories funded receive a supplement from income taxes.

Medicaid

In the event of comprehensive tax reform, which would include tax simplification at the higher end and individual income tax elimination at the lower end, the subsidies provided to high income tax states and municipal bond issuers would vanish. In order to soften the blow for ending this subsidy, Len Burman, late of the Tax Policy Center, and I both agree that Medicaid should be entirely federalized.

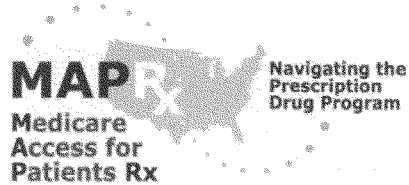
In the event that the NBRT includes tax subsidies for covering retired workers and workers in remedial and job training programs – whether they are operated by the employer or merely funded by them through private sources, the impact on federalizing Medicaid funding will be profound as caseloads drop, and with them local government payrolls.

If states governments mirror federal tax reform, the other possibility is for the federal NBRT to be lowered while states raise their rates to compensate for the lack of federal funding – but with those states gaining from employers picking up the cost in exchange for a tax benefit.

The most profound cost savings available to lower Medicaid costs, however, comes from the replacement of current federal nutrition programs, which can be quite parsimonious in their funding, with participation in the expanded Child Tax Credit as part of remedial training. Such participation allows people who now struggle at the end of the month to feed themselves and their children to afford a diet with more meat, fruit and vegetables and less cheap starches – which are often the staple of diets for those on public assistance due to their low cost. A healthier diet will quickly lower the rate of obesity among the poor, and with it the costs related to early onset diabetes and its complicating prevalence of heart attack, hypertension and stroke. This will, in turn, lower health care costs for both public Medicaid and for private insurance offered to clients of remedial education programs.

Government nutrition and welfare programs have often been penny-wise and pound foolish – for example lowering doctor reimbursements while driving people to Emergency Room care and refusing to mandate sick leave for all so that workers can take their children to the doctor rather than dragging them to the ER at night. The tax reform proposals I have outlined reverse that trend and will, in the long run, save money.

Thank you for the opportunity to address the committee.



Statement for the Senate Finance Committee Hearing:

**Health Care Entitlements: The Road Forward
June 23, 2011**

Submitted by:

**MAPRx
2000 L Street, NW
Suite 410
Washington, DC 20036**



Navigating the
Prescription
Drug Program

June 23, 2011

The Honorable Max Baucus
Chairman
U.S. Senate Finance Committee
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
U.S. Senate Finance Committee
Washington, DC 20510

Dear Senator Baucus and Senator Hatch –

MAPRx is a coalition formed in response to the passage of the Medicare Modernization Act, which created the Medicare Prescription Drug program (Part D). MAPRx brings together beneficiary, family caregiver and health professional organizations committed to improving access to prescription medications and safeguarding the well-being of beneficiaries with chronic diseases and disabilities who are enrolled in Part D.

As the Finance Committee today begins consideration of the long-term future of entitlement programs such as Medicare, MAPRx is writing to urge that you consider the very critical needs of people with chronic conditions who rely on the Part D program for access to life-saving and/or life-changing medications. As a group, we recognize the very real need to address the challenging fiscal situation facing the nation. However, we strongly believe that savings cannot and will not be achieved by significant cuts to Medicare, particularly Part D, that restrict or eliminate access to medications that help beneficiaries better manage chronic conditions and innovative, breakthrough therapies that address complex diseases with few if any treatment options. On the contrary, such draconian measures may have immediate returns but drastic long-term consequences for beneficiaries, the Medicare program and the nation.

As the Committee focuses on the future of Medicare and the need to control costs, MAPRx asks that you recognize the importance of these specific issues:

- Avoid onerous cost-shifting that places financial burdens on beneficiaries;
- Allow Medicare beneficiaries to request tiering exceptions for drugs placed on specialty tiers;
- Limit or eliminate restrictive medication utilization management;
- Retain the six protected classes;
- Eliminate the two-year eligibility wait period; and
- Ensure comparative effectiveness research does not restrict access.

Avoid Onerous Cost-Shifting onto Beneficiaries

Unfortunately, this practice already occurs in the Part D program as more and more prescription drug plans have added to their formulary a "specialty tier" for high-cost medications. Unlike lower cost medications, for which beneficiaries usually pay a set co-pay amount, these medications are subject to significant co-insurance, meaning that beneficiaries must pay a percentage of the medication's cost. For drugs on the specialty tier, this amount can be anywhere from 25-33%, leaving patients to pay thousands of dollars out of pocket for the very expensive drugs and biologics used to treat cancer, multiple sclerosis, hemophilia, rheumatoid arthritis and other conditions. For many beneficiaries, the result is that they are denied access to the most appropriate, useful medication due to the fact that it is financially out of reach. For those who can afford the drugs, they pay enormous sums out of pocket to maintain their health.

MAPRx is extremely concerned about the current levels of cost-shifting occurring in the Part D program. We strongly believe that no one relying on Part D should be denied access to needed medications simply because they cannot afford them. Furthermore, this has negative consequences for the Medicare system as a whole. As people do not get the best, most appropriate medications for their condition(s), their health outcomes will be less than ideal, often resulting in dramatically higher costs in the other parts of Medicare.

MAPRx urges the Committee to resist imposing additional burdensome cost-sharing on Part D beneficiaries as a cost-saving strategy for Medicare.

Allow Part D Beneficiaries to Request Exceptions for Specialty Tier Drugs

The Medicare Modernization Act of 2003 requires that if a Part D plan utilizes a tiered cost-sharing structure to manage its Part D drug benefits, the plan must establish and maintain reasonable and complete exceptions procedures that permit enrollees to obtain a non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier (Public Law 108-173-Dec. 8, 2003, 117 STAT.2090)

The Center for Medicare and Medicaid Services (CMS) has allowed drug plans to utilize specialty tiers for drugs with a monthly cost threshold at or above \$600, but the agency promulgated regulations that allow plans not to apply exception procedures for such tiers. MAPRx members believe this is a direct contradiction of Congressional intent when passing the Medicare Modernization Act, and we urge Congress to restate its legislative intent to provide beneficiary protections for qualified prescription drug coverage.

Limit or Eliminate Restrictive Medication Utilization Management

In addition to higher cost-sharing, many Part D plans now employ medication utilization management tools, such as prior authorization, medication substitution or quantity limits, to control costs. One of the most troubling policies is “fail first,” which requires that beneficiaries prescribed an expensive medication first use a less expensive medication and find it does not work before the plan will pay for the original prescription.

These policies are designed to control costs by placing unnecessary barriers to patients accessing the medications specifically recommended by their doctor. Not only are these policies a complete infringement on the doctor-patient relationship, they are extremely shortsighted, undermining the health and well-being of beneficiaries. Requiring patients to potentially see their health deteriorate before they gain access to a doctor-prescribed treatment harms the beneficiary and increases the overall costs to the Medicare program. Neither is worth the short-term cost-saving gain.

These policies should be severely limited in the current Part D structure but must not be expanded as a cost-saving strategy going forward. MAPRx strongly recommends that the Committee avoid such policies as it considers ways to ensure continued solvency for Medicare.

Retain the Six Protected Classes

Guidance from CMS directs Part D plans to cover all or substantially all of the drugs in six protected classes: anti-neoplastics, immune suppressants, anti-retrovirals, anti-convulsants, anti-depressants, and anti-psychotics. This ensures that beneficiaries living with chronic conditions have access to the full range of treatments, thereby guaranteeing that they can get the best therapy as recommended by their physician. CMS has in the past proposed – but did not implement – changes to the regulations that included an exception to the requirement to cover “all” drugs in a class.

MAPRx opposes any weakening of the protected classes, which would only serve to place another barrier between beneficiaries and the medications they need. Placing limits on the covered drugs under the protected classes could potentially be seen as a cost-saving strategy. Like medication utilization management policies, such an approach would be shortsighted and counterproductive. MAPRx asks that the Committee avoid any attempt to place limits on the protected classes as a means of cost reduction.

Eliminate the Two-Year Waiting Period for Medicare

In addition to providing health care coverage for Americans over 65, Medicare covers nearly 7 million people with severe and permanent disabilities who receive Social Security Disability Insurance (SSDI) benefits. However, those receiving such benefits must wait two years from their initial eligibility for SSDI

until they are eligible for Medicare. This two-year waiting period exposes millions of Americans to financial strain as well as pain and suffering. Congress has already acknowledged that the waiting period is catastrophic or even life-threatening for some by eliminating it for people with amyotrophic lateral sclerosis (Lou Gehrig's disease) and end-stage renal disease.

MAPRx believes it is time to spare anyone who qualifies as disabled from such consequences by eliminating the two-year waiting period for all. While this delay may save money initially, it likely increases overall Medicare costs by virtually ensuring that those receiving SSDI are suffering poorer health outcomes when they finally do become eligible for Medicare. MAPRx asks the Committee to consider overturning or at least easing this perverse policy as a means to both improve patient care and place Medicare on stronger financial ground.

Ensure Comparative Effectiveness Research Does Not Restrict Access

Comparative effectiveness research, which seeks to evaluate similar treatments or therapies, must not be allowed to determine coverage or reimbursement of treatment or interfere with a physician's ability to determine the best treatment in consultation with their patient. Although MAPRx supports funding for efficacy studies of various treatment options, we are aware of the limitations of such research, which may not take into account variations among individuals and subpopulations in any patient community. Evaluation of treatments, used to guide the medical community, must occur in real healthcare settings to determine their impact on individuals and various unique subpopulations such as those with chronic illness or disability.

Although widely viewed as a tool to make the health care system more consistent, safe, efficient, and affordable, comparative effectiveness research should never be used to deny coverage for drugs or treatments. MAPRx asks that the Committee reemphasize its commitment to this approach, as stated in the Affordable Care Act language related to this issue. It must remain a top priority that beneficiaries have access to the medications needed to improve or maintain their health, as was the intention of the Part D program.

MAPRx is aware of the very difficult fiscal environment facing the nation and appreciates the challenges the Committee confronts as it attempts to both control costs and ensure the long-term viability of Medicare. However, we must also state our concern regarding potential cuts or policies that may produce savings in the near term only to harm beneficiaries and ultimately drive up costs. It is essential that any steps to address costs in Medicare be thoughtful, well-planned, and, ultimately, constructed with beneficiaries in mind.

MAPRx thanks the Committee for the opportunity to provide these comments and recommendations. Furthermore, MAPRx and its members look forward to continued engagement with the Committee on ways to improve the Part D

program so that it better serves current and future beneficiaries. For questions related to MAPRx or the above comments, please contact Mary Beth Buchholz, Convener, MAPRx Coalition, at (202) 637-9732 ext 229 or Marybeth@maprxinfo.org.

Sincerely,

The AIDS Institute

The ALS Association

American Autoimmune Related Diseases Association

American Society of Consultant Pharmacists

Arthritis Foundation

Easter Seals

Epilepsy Foundation

Hemophilia Federation of America

The Lupus Foundation of America

Men's Health Network

Mental Health America

National Alliance on Mental Illness (NAMI)

The National Grange

National Kidney Foundation

National Multiple Sclerosis Society

National Osteoporosis Foundation

National Psoriasis Foundation

Parkinson's Action Network

RetireSafe

United Spinal Association



NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

Statement
Of
The National Association of
Chain Drug Stores
For
United States Senate Committee on Finance
Hearing on
Health Care Entitlements:
The Road Forward
June 23, 2011
10:00 a.m.

National Association of Chain Drug Stores (NACDS)
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Introduction

The National Association of Chain Drug Stores (NACDS) recognizes the importance of entitlement reform and appreciates the opportunity to share our views on how our industry can help control future cost growth in Medicare and Medicaid. Pharmacies are the face of neighborhood healthcare, and are a highly valued and trusted source of care for millions of Americans. NACDS and its member companies have a long history of partnering with Congress, state policymakers, and other stakeholders in providing best practices and other strategies to control healthcare costs. We stand ready to continue this partnership as Congress considers proposals to reform the Medicare and Medicaid programs.

Pharmacists are our health system's medication experts, and professional services provided by community-based pharmacists help ensure the safety and effectiveness of patients' medication therapy. As highly trained and accessible healthcare providers, pharmacists are uniquely positioned to play an expanded role in increasing medication adherence and actively engage patients in their own healthcare and medication self-management by providing a variety of pharmacist-delivered services, such as medication therapy management (MTM) and immunizations. Services provided by community pharmacists are an essential part of improving patient compliance, improving the delivery of healthcare services, improving quality and outcomes, and are a cost effective and convenient way to prevent illness and reduce healthcare costs to the Medicare and Medicaid programs.

The following recommendations suggest specific ways in which policymakers can take full advantage of community pharmacies in reforming and strengthening the Medicare and Medicaid programs.

Strengthen the Medication Therapy Management Benefit in Medicare Part D

The best way to make sure Americans use medications most effectively is through complete medication reviews and professional counseling services offered by qualified pharmacists, otherwise known as "medication therapy management." MTM prevents medication errors, ensures medication compliance and gets patients more involved in their medication therapy. Pharmacists are the most highly trained professionals in medication management. They receive a minimum of six years and in many cases eight years of college, with four years enrolled in a College of Pharmacy where they study medication uses, dosing, side effects, interactions and patient care. As highly trained and accessible healthcare providers, pharmacists are uniquely positioned to play an expanded role in ensuring patients take their medications as prescribed.

Evidence shows that MTM improves patient outcomes and reduces unnecessary medical spending. In the North Carolina "Checkmeds" program, MTM helped 31,000 seniors save \$34 million in one year -- a return on investment of nearly 14 to 1. The January 2011 edition of *Health Affairs* found that better medication adherence produced annual savings of \$7,823 for patients with congestive heart failure, \$3,908 for those with hypertension and \$3,756 for diabetic patients. In addition, a comprehensive medication review program by one major pharmacy chain

showed a nearly 3-to-1 return on investment, with Part D savings of over \$36 per member per month for seniors in the program.

We appreciate that Congress, and the Finance Committee in particular, has recognized on a bipartisan basis the important contribution that MTM makes to improved outcomes and reduced costs. The Medicare Modernization Act of 2003, which created the Medicare Part D drug benefit, specifically included MTM as a required offering. The Patient Protection and Affordable Care Act of 2010 also made improvements to the Part D MTM benefit and established grant programs for MTM in treating chronic diseases and in care provided in the new “medical home” model. While these steps are welcome, more needs to be done to control the huge costs associated with medication non-adherence and to improve seniors’ access to MTM services.

We are convinced that MTM is a key way to help vastly improve our healthcare entitlement programs by ensuring that beneficiaries receive the maximum health benefit from their prescription medicine. As noted above, currently the Medicare Part D program includes an MTM benefit, but the requirements are vague, and have resulted in inconsistent availability to beneficiaries. To ensure that individuals receiving prescription medications through Medicare Part D are provided with all the tools they need to improve their healthcare outcomes and reduce overall program expenditures, NACDS supports S.274, the Medication Therapy Management Empowerment Act of 2011 sponsored by Senator Kay Hagan (D-NC). The Act strengthens the Medicare Part D MTM program requirements including services such as an annual comprehensive medication review for eligible beneficiaries and expands eligibility standards to include beneficiaries with only one chronic disease, dual eligible beneficiaries enrolling in Medicare for the first time, and beneficiaries in transitions of care, such as those recently discharged from a hospital or other institutional setting. Such beneficiaries are likely to have new medications, including the need for diabetic medications and supplies, and would benefit from a targeted intervention by a pharmacist. We urge members to co-sponsor S.274.

Utilize the Medicare Part D Program’s Efficiencies for Diabetes Supplies

Approximately 26 million children and adults in this country suffer from diabetes, and another 79 million Americans are pre-diabetics¹, making diabetes a major national problem of concern to all Americans. Medicare beneficiaries have no better source for receiving their prescription medications and other healthcare services and advice on how to best utilize them than from their neighborhood retail pharmacy. Currently, prescription drugs related to diabetes, such as insulin, are provided to Medicare beneficiaries through Part D. However, durable medical equipment (DME), such as diabetes monitors and testing strips, are provided to Medicare beneficiaries through Part B. This results in difficulties in coordinating care, and increased costs. NACDS believes that diabetes supplies should be incorporated into the Medicare Part D benefit. This change would mirror commercial practices, would allow diabetic patients to access necessary medications and DME from one healthcare provider, and would reduce costs, both by moving

¹ Centers for Disease Control and Prevention, *2011 National Diabetes Fact Sheet*.
http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf

additional products to the more efficient Part D program, and by improved health outcomes for patients.

Under the current rules governing the Medicare competitive bidding program, seniors are still able to purchase their diabetic testing supplies through their local retail pharmacy. When developing the competitive bidding program Congress intentionally left retail community pharmacies out of the program to ensure continued access to quality supplies and face to face consultation with a pharmacist. In order to ensure continued beneficiary access, Congress should not consider moving retail pharmacy-supplied diabetes testing equipment into the Medicare competitive bidding program, nor should it take steps to reduce the reimbursement amount for the retail setting to match the mail order rates.

Early results from round one of the competitive bidding program have shown that seniors have relied on their retail community pharmacies for their specific brand of diabetic testing supplies as well as the invaluable consultation of a knowledgeable pharmacist. We urge Congress to maintain the current exemption of diabetes testing supplies furnished by retail pharmacies from the competitive bidding program for all retail pharmacies providing diabetes testing supplies for Medicare beneficiaries. Moving retail diabetes supplies into the competitive bidding program, or decreasing the reimbursement rates to the mail order level could significantly reduce access to local pharmacies as a source for these supplies. Retail pharmacies are a critical access point for Medicare beneficiaries with diabetes. In fact, 40% of all seniors with diabetes currently obtain their DME from retail pharmacy locations. This allows seniors to obtain from a single source all the equipment and prescription drugs they need to manage their diabetes, i.e. a local pharmacy. Limiting access to supplies and pharmacist consultation could lead to under-testing and decreased medication adherence, poorer outcomes and increased costs.

Expand Coverage of Vaccines in Medicare Part D

Neighborhood retail pharmacies have played an integral role in recent years in providing vaccinations and immunizations against such illnesses such as H1N1 flu. Despite the availability of effective immunizations, many Americans remain unvaccinated and susceptible to vaccine-preventable diseases. An Institute of Medicine Report estimates that more than 50,000 adults and 300 children in the United States die each year from vaccine-preventable diseases or their complications.² However, the United States Department of Health and Human Services has found that immunizations, including those administered by pharmacists, help prevent 14 million cases of disease and 33,000 deaths yearly.³

Currently all 50 states allow pharmacists to provide immunizations. Encouraging Medicare beneficiaries and others to obtain vaccinations at their neighborhood pharmacy is a cost effective and convenient way to prevent illness and reduce healthcare costs. Notably, the Department of

² Institute of Medicine Report. Shaping the Future For Health – Calling the Shots – Immunization Finance Policies and Practice. http://books.nap.edu/html/calling_the_shots/reportbrief.pdf

³Department of Health and Human Services, Fiscal Year 2008. Centers for Disease Control and Prevention. *Justification of Estimates for Appropriation Committees*. Available:http://www.317coalition.org/documents/cdc_fy2008budget_immunization.pdf.

Defense not only allows its beneficiaries to obtain vaccinations at local pharmacies, it encourages them to do so by waiving cost sharing when pharmacies are used for immunizations.

In order to create a streamlined, consistent, and more cost effective vaccine policy, NACDS believes Part B vaccines should also be available under Medicare Part D. We believe this policy would increase immunization rates in target populations since pharmacists are the most accessible healthcare provider. The Medicare program would also benefit from the efficient, electronic-based processing of vaccine claims, which occurs in Part D. This will help move the system toward greater use of health information technology, a proven cost saver.

Allow Storage of Scanned Prescriptions in Medicare Part D

Pharmacies can play an important role in facilitating electronic health records. The Medicare Modernization Act requires prescriptions to be maintained for 10 years. Currently, pharmacies must retain a hard copy of prescriptions for three years, and then are permitted to maintain them electronically. This adds needlessly to the cost of healthcare and is inconsistent with policymakers' interest in encouraging electronic health records, as required by the Electronic Signatures in Global and National Commerce (E-SIGN) Act (P.L. 106-229).

In order to spur the adoption of health information technology (HIT), combat fraud, waste, and abuse, and comply with current law, pharmacies should be permitted to retain prescriptions in electronic form for the entire 10-year period. Scanned prescriptions stored electronically would be easier to access should investigations into fraud, waste, and abuse take place, and would reduce costs and administrative burdens for pharmacies.

Increase the Utilization of Generic Drugs

Pharmacists are also leaders in promoting cost savings, helping educate consumers and providers about affordable alternatives like generic drugs and over-the-counter remedies. Pharmacies have long promoted generic drugs as safe, cost-effective alternatives for many patients. Substituting generic pharmaceuticals for their brand-name equivalents or other brand name drugs within the same drug classes is a cost-effective way of achieving Medicaid savings.

Community pharmacies are leading the way to maximize the appropriate use of generic drugs. Community pharmacy has a higher rate of generic dispensing--71%- than any other practice setting, including mail order pharmacy. In calendar year 2010 the generic dispensing rate increased by 3.8% from 2009⁴. For every 1% increase in generic utilization, the Medicaid program could save approximately \$468 million. The Massachusetts fee for service Medicaid program has the highest generic dispensing rate in the nation, at 79.3%. If all other states could match the Massachusetts rate, the Medicaid program could save \$5.14 billion. Medicaid programs generally have a good generic dispensing rate, but greater savings could be achieved by encouraging or mandating more aggressive prescribing of generic drugs. We believe that there are many best practices that could be put in place to reduce Medicaid spending, while at the same time allowing Medicaid patients to continue to use the pharmacy of their choice.

⁴ Wolters Kluwer Health Source® Pharmaceutical Audit Suit

We appreciate the support of the Finance Committee and Chairman Baucus for ensuring that the Patient Protection and Affordable Care Act (P.L.111-148) (PPACA) included provisions to reform the Average Manufacturer Price (AMP) methodology for determining Medicaid reimbursement for generic drugs. These important reforms corrected a reimbursement methodology that would have put 20% of all pharmacies at risk, particularly those serving low income Americans. As the Centers for Medicare and Medicaid Services works on a formal rulemaking to implement these provisions, we ask for your continued support to ensure that pharmacy reimbursement is fair, accurate and sufficient to cover the cost of dispensing Medicaid prescriptions. Reimbursement that is inaccurate or too low would create disincentives to the dispensing of generic medications, which in turn would result in higher costs and less sustainability to the Medicaid program – and reduced access to local pharmacies.

State Option to Provide Health Homes for Medicaid Enrollees with Chronic Conditions

The Patient Protection and Affordable Care Act includes a series of grants and pilot programs aimed at improving healthcare quality and controlling costs through the use of coordinated care models. As a potential cost savings initiative, states now have the option to create a health home for Medicaid beneficiaries with chronic conditions which would include services such as care coordination and comprehensive care management.

As an avenue to increasing medication adherence, coordinated care models can improve patient care by promoting safe and effective medication use. Successful outcomes for coordinated care models are dependent on making sure multiple provider types are able to provide their services to beneficiaries. Through coordinated efforts with other healthcare providers, community pharmacists play an important role in ensuring patients take their medications as prescribed. This will improve health outcomes and reduce the use of more costly medical interventions such as hospitalizations and emergency room visits.

Conclusion

NACDS would like to thank the Finance Committee for the opportunity to submit our recommendations on ways in which community pharmacies can help with reforming and strengthening the Medicare and Medicaid programs. Community pharmacists play a critical role in increasing medication adherence which can lead to improved health outcomes and reducing overall healthcare costs to the Medicare and Medicaid programs. NACDS and its member companies look forward to continuing the partnership with Congress, state policymakers, and other stakeholders to create cost effective and efficient ways to continue providing access to quality healthcare services to Medicare and Medicaid beneficiaries.

National Association of
Children's Hospitals

Champions for Children's Health



N • A • C • H

**National Association of Children's Hospitals
401 Wythe Street
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Statement for the Hearing Record
Senate Committee on Finance, June 23, 2011 Hearing:
Health Care Entitlements: The Road Forward**

The National Association of Children's Hospitals (N.A.C.H.) represents 223 children's hospitals across the country. These children's hospitals play an important role in their communities as major safety net institutions for children. While children's hospitals make up less than five percent of all hospitals, they account for 47 percent of the hospital care for children who rely on Medicaid and almost all the hospital care for children with complex medical conditions. Children's hospitals also advocate for protections and services for children and families, including public health education, injury prevention and access to appropriate health care. Children's hospitals truly serve as the safety net for children, filling the unique needs of their communities.

As Congress confronts the ongoing need to reduce the federal deficit, we urge lawmakers to protect the Medicaid program's long-term viability and role as a vital provider of care for our nation's children. Medicaid is the single largest health insurer for children, covering more than one in four children. It is also the single largest payer for children's hospitals; children insured by Medicaid account for, on average, over 56 percent of all inpatient days of care provided by freestanding children's hospitals.

Children's hospitals are committed to working to make this program the best it can be and believe that there is much we can do together to preserve and improve the program. While we recognize the importance of reducing the deficit, we urge lawmakers to avoid structural changes to the Medicaid program that simply shift costs to states and local governments, providers, or beneficiaries without actually slowing growth in underlying health care costs.

Changing the fundamental financing and entitlement structure of Medicaid could further undermine access to care. Proposals that would cap federal support for Medicaid would leave states with few options other than reducing already low provider payment rates or eroding our current system of care by cutting benefits or limiting eligibility.

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Children have historically enjoyed special protection under the Medicaid program in acknowledgement of the vulnerability of the population and its unique needs. An example is the Early and Periodic Screening, Diagnostic and Treatment benefit that entitles them to medically necessary care. Consistent with these protections, any deficit reduction proposal, as a fundamental principle, must not jeopardize access to care for already vulnerable populations.

Children's ability to access needed care goes directly to the core of children's hospitals' mission. Over the years Medicaid has often provided inadequate payments for services, which leads to barriers to access to care for children covered by Medicaid. On average, Medicaid reimburses children's hospitals only 79 percent of the cost of care provided, even with disproportionate share hospital (DSH) payments included in the calculation of total payment. Pediatricians, who provide the majority of office-based preventive care services for children, on average receive only 72 percent of what Medicare pays for the same service.

Many children also face tremendous access to care challenges due to a national shortage of pediatric specialists across the country. The predominance of Medicaid as a payer for children's health care provides a disincentive for young physicians to enter pediatric specialties. Since physicians must complete a pediatric residency before training for their specialty, they stay in training three years longer than their counterparts who focus on an adult population. Once they begin to practice, they depend on a payer mix that is dominated by Medicaid, which pays them significantly less than Medicare would pay for the same services creating an economic disincentive to enter this field.

Children's hospitals are working to be part of the solution to the pediatric specialist shortage. They often provide support to physician practices to ensure the availability of necessary pediatric specialties in their communities. Many form community clinics, partnerships and innovative care models to reach those children who might not otherwise have access to care. Children's hospitals also provide education and training for the new generation of pediatric providers; the average children's teaching hospital trains twice as many residents per bed as the average adult teaching hospital. Since 2000, children's hospitals have more than doubled the number of total pediatric specialty residents from 1,067 to 2,366.

Despite these efforts, many children's hospitals report vacancies of 12 months or longer in many specialties. To give one example that illustrates the challenge: the Montana Pediatric Project at St. Vincent's Healthcare in Billings is trying to recruit pediatric providers so that children can receive the care they need in Montana. According to the recruiter with the physician group at

the hospital, pediatric positions are the hardest to recruit; in fact, there is only one pediatric surgeon in the entire state – based in Missoula, MT. St. Vincent's has been trying to recruit a pediatric surgeon for the past 24 months.

We believe that real Medicaid reforms that lead to better care and lower costs are possible, while maintaining the protections children rely upon. We are very interested in working with the Administration and Congress to realize this potential. Children's hospitals are already adopting innovative care models and are ready to embrace additional opportunities to improve the delivery of coordinated pediatric health care that can address long-term budgetary concerns. For example:

- Children with complex chronic conditions are experiencing better, higher quality care and reduced health care costs through several children's hospitals medical home programs. Through better care coordination and integration, with the patient and their families as partners, these programs have been able to reduce hospitalizations and ER visits. In addition, they have shown high patient and family satisfaction and better quality of life for the family and the child. There is great potential if these programs could be expanded to all children with chronic conditions.
- As Medicare moves ahead with their ACO guidance, there has not been any movement from the federal agencies on the Pediatric ACO demonstration included in the ACA. We believe children should be included in the opportunity for better integrated and coordinated care through ACO models. Although ACOs are even newer to the Medicaid and pediatric populations, we believe a demonstration should be set up to test out models on how best to build an ACO for children that could reduce costs and improve quality. Several children's hospitals are ready to be partners in this effort.

Medicaid is a vital program for our institutions, our physicians and allied health professionals, and the children and families that we serve. Without this vital safety net, we would be unable to provide the care that we do today. Working with Congress, we can do even more to improve primary and specialty care for our country's children while, at the same time, develop more efficient programs that will yield significant cost savings.

Statement of the National Community Pharmacists Association (NCPA)**United States Senate Committee on Finance****Hearing on Healthcare Entitlements: The Road Forward****June 23, 2011**

The National Community Pharmacists Association (“NCPA”) welcomes and appreciates this opportunity to provide input and suggestions regarding efforts to eliminate waste and generate savings within healthcare entitlement programs, particularly as they relate to pharmacy care providers. NCPA represents the pharmacist small business owners, managers and employees of more than 23,000 independent community pharmacies across the United States. The nation’s independent pharmacies, independent pharmacy franchises and independent chains dispense nearly half of the nation’s retail prescription medicines.

The Federal government pays for tens of billions of dollars in prescription drug programs for Medicare Part D, Medicaid fee for service and Medicaid managed care, FEHBP, TRICARE and other programs. NCPA strongly believes in the mission to cut waste and retain savings in federal health care programs in order to maximize the benefits that those programs provide to beneficiaries. NCPA and our members stand willing and able to assist Congress in realizing these savings and offer our services to streamline the delivery of pharmaceutical products and to promote cost-effective health care. Accordingly, NCPA urges Congress to recognize the role that independent community pharmacies can play in reducing spending on prescription drugs and avoiding preventable yet costly encounters with the health care system including emergency room visits and hospitalizations.

NCPA believes that significant waste exists in the delivery of these government-funded and government-subsidized prescription drug programs. Billions of dollars in savings remain “on the table” because of the lack of competition and oversight in the management of drug benefits in these programs by pharmacy benefit managers (PBMs). In addition, improving the overall quality of medication use for patients in these programs through enhanced pharmacy care and medication therapy management (“MTM”) would also reduce spending by keeping patients out of the hospitals and emergency rooms. Common-sense, market-based reforms to these programs could reduce Federal government drug costs as well as reduce premiums and co-pays paid by both private and public sector consumers.

Recommendations

NCPA and independent community pharmacists are committed to eliminating waste and capturing savings within federal healthcare programs. We offer a number of proposals for achieving those goals.

- Promote policies that encourage the appropriate use of generic drugs in the Medicaid, Medicare Part D and TRICARE programs – where generic drug use is lacking as compared to the private sector plans, which have a generic drug utilization rate of about 72 percent;¹
- Ensure that PBMs return to the federal government billions of dollars in manufacturer rebates that the PBMs retain from federal healthcare programs. This is especially important in the Medicare Part D programs and Medicaid managed care programs. The HHS Office of Inspector General (“OIG”) has stated that a lack of transparency by PBMs raises concerns that Part D plan sponsors may not have enough information to ensure that beneficiaries and taxpayers are receiving the benefit of rebates from drug manufacturers;
- Require PBMs to place a priority on effective fraud reduction and mitigation efforts. To that end, PBMs under contract to federal health care programs should be required to place an emphasis on attacking this problem of fraud rather than targeting legitimate pharmacies and recouping large sums of money for technical and administrative errors. Moreover, PBMs should also be required to transfer recovered amounts to the appropriate plan sponsors to reduce costs to beneficiaries and taxpayers rather than retaining these funds as revenue for the PBMs;
- Promote greater use of lower cost generic drugs by requiring PBMs to disclose publicly the generic dispensing rates of PBM-owned mail order pharmacies and the amount of manufacturer rebates received to increase the utilization of brand-name drugs. This is especially important in the TRICARE pharmacy program where the generic use rate in mail is 51 percent, well below the retail pharmacy generic dispensing rate of 72 percent.²
- Pass *S. 1058, the Pharmacy Competition and Consumer Choice Act of 2011*, sponsored by Senators Pryor and Moran, which promotes PBM transparency and will highlight savings to be attained from PBM reforms;
- Pass *S. 274, The Medication Therapy Management Empowerment Act of 2011*, sponsored by Senators Hagan and Franken, which would expand the delivery of MTM services to Medicare Part D beneficiaries to reduce health care costs resulting from unnecessary emergency room utilization and preventable hospitalizations caused by medication therapy problems
- Pass *H.R. 1936, the Medicare Diabetes Access to Care Act*, sponsored by Congressmen Schock and Welch, which preserves effective management of diabetes by ensuring continued Medicare beneficiary access to diabetic testing supplies and counseling supplied by community pharmacies.

¹ Based on statistics contained within the 2010 10K SEC filings for the big 3 PBMs.

² Based on statistics provided to NCPA by the TRICARE Pharmacy Program.

Increase Use of Lower-Cost Generic Medications

Generic drugs are one-fifth of the cost of brand name drugs. Nothing can save the health system more money than using generic medications where appropriate, even after accounting for the lucrative rebates that PBMs earn on brand name drugs. Yet, many Federal programs generic dispensing rates are lower than the national average.

The Congressional Budget Office (“CBO”) recently reported that the generic dispensing rate in Medicare Part D is 64%³ and the generic dispensing rate in Medicaid is 68%⁴ according to a study by the Generic Pharmaceutical Association. This falls short of the generic utilization in retail pharmacies of approximately 72%.⁵ Mail order generic dispensing rates are much lower. The increased use of mail order drives up drug spending and results in fewer opportunities for face to face interventions by pharmacists. These interventions improve drug therapy and reduce health care spending on expensive health care encounters in the hospital emergency room. Greater reliance on the delivery of prescription drugs through retail pharmacy will improve generic dispensing rates in federal healthcare programs, thereby achieving billions of savings over the existing system. Here is a comparison of generic dispensing rates of mail order pharmacies to retail pharmacies:

Mail Order Generic Dispensing Rates⁶

CVS/Caremark	61.3%
Medco	61.5%
Express Scripts	60.2%

Community Pharmacies Generic Dispensing Rate⁷

72%

Collect Billions of Dollars in Manufacturer Rebates Being Retained by PBMs

Most federal programs use pharmacy benefit managers (PBMs) to administer drug benefits. These include Medicare Part D, Medicaid, FEHBP, and TRICARE. Yet, the federal government is unable to determine accurately whether PBMs are passing through to taxpayers or beneficiaries the billions of dollars in rebates they receive from manufacturers for drugs covered for enrollees in these Federal programs. In addition, federal programs are not currently tracking whether PBMs retain a percentage of total manufacturer rebates as well as funds that are intended for pharmacy professional services and cost of dispensing.

³ Congress of the United States, Congressional Budget Office, *Effects of Using Generic Drugs on Medicare's Prescription Drug Spending*, September, 2010.

⁴ Generic Pharmaceutical Association, *Economic Analysis of Generic Pharmaceuticals 1999-2008. \$734 Billion in Health Care Savings*, May 2009

⁵ Based on statistics contained within the 2010 10K SEC filings for the big 3 PBMs.

⁶ *Id.*

⁷ Preliminary data from 2011 NCPA Digest, National Community Pharmacists Association.

There is cause for concern. A recent OIG report found that for the year 2008, Part D sponsors received \$6.5 billion in rebates, yet some sponsors may be inappropriately allocating rebates across their plans in order to maximize reconciliation payments inappropriately.⁸ Notably, according to the OIG, most PBMs did not pass the full amount of rebates onto beneficiaries, and only 4 out of 258 sponsors provided rebates to beneficiaries at the point of sale.⁹

The OIG also found that sponsors underestimated rebates in 69% of their bids and 78% of Part D beneficiaries were enrolled in plans that underestimated rebates.¹⁰ These underestimations lead to higher premiums for Part D beneficiaries and overpayments by CMS. This high percentage of underestimates may indicate that some PBMs deliberately underestimate their rebates in order to increase their profits. There is no consistency, uniformity or transparency in determining whether or how these rebates are going to lower drug costs in these programs. Congress should take action to bring transparency to what happens to these rebates and force PBMs to pass through these rebates to the federal government and beneficiaries.

Refocus Government Fraud Efforts on Truly Fraudulent Activities

The Federal government is legitimately focused on assuring program integrity. We work closely with Federal and state agencies to assure that there is nothing but the highest program integrity in the government programs in which we participate. However, government policymakers should be concerned about the potential for fraud in PBM-administered programs. There are numerous settled and active cases of fraud against PBMs which should raise policymakers' concerns. Here are just a few:

- In *State Attorneys General v. Express Scripts, Inc.* (filed May 27, 2008), State Attorneys General in 29 states and the District of Columbia settled consumer protections claims against Express Scripts for \$9.3 million plus up to \$200,000 reimbursement to affected patients. The claims resulting in settlement alleged that Express Scripts engaged in deceptive business practices by illegally encouraging doctors to switch their patients to different brand name drugs for the purpose of saving the patients and their health plans money despite the fact that these switches did not necessarily result in any savings for the patients or the plans, but actually resulted in higher margins and bigger rebates for Express Scripts. The settlement also prohibited Express Scripts from soliciting drug switches under specified circumstances.
- In *States Attorneys General v. Caremark, Inc., et al.* (filed Feb. 14, 2008), 28 states and the District of Columbia issued complaints and consent orders against Caremark and two of its subsidiaries: Caremark, L.L.C. and CaremarkPCS, L.L.C. (formerly AdvancePCS) for their alleged illegal drug switching practices, which violated each of the States' Consumer Protection Acts. In conjunction with the complaints, the States each also issued a consent decree/final judgment with Caremark agreeing to a collective settlement of \$41 million (\$38.5 million to the states and \$2.5 million in reimbursement to patients who incurred expenses related to certain switches between cholesterol-

⁸ Department of Health and Human Services, Office of the Inspector General, *Concerns with Rebates in the Medicare Part D Program*, Daniel R. Levinson, March, 2011, OEI-02-08-00050.

⁹ *Id.*

¹⁰ *Id.*

controlling drugs). The States alleged that Caremark engaged in deceptive trade practices by deceptively encouraging doctors to switch patients from originally prescribed brand drugs to different brand name prescription drugs.

- In *In re Pharmacy Benefits Managers Cases*, No. JCCP4307 (Cal. Super. Ct. May 30, 2003), the Prescription Access Litigation Project (PAL) and the American Federation of State, County, and Municipal Employees (AFSCME), AFL-CIO, filed suit against the nation's four largest PBMs for inflating prescription drug prices. The lawsuit alleged that through a pattern of illegal, secret dealings with drug companies the PBMs forced health plans and health care consumers to pay inflated prescription drug prices and reaped billions of dollars in illegal profits by steering health insurers and health care consumers into reliance on more costly drugs. This case is currently pending in the California Superior Court of Los Angeles County as of December 6, 2010.

Moreover, last year, community pharmacies had difficulty collecting tens of millions of dollars in reimbursement for legitimately-dispensed prescriptions from a Part D plan that was terminated by CMS from the Medicare Part D program midyear. Based on our interactions with CMS to try and get claims paid for these legitimately-dispensed prescriptions for beneficiaries, it appears that CMS had no statutory recourse to require the plan to pay pharmacies for these prescriptions. CMS stated that it lacked authority to intervene, even though CMS prepay Part D plans each month for each Part D beneficiary enrolled in the plan. This meant that in this case, CMS had already paid the terminated plan its per member per month payment for the period of the unpaid claims. The result was that taxpayers' funds were already in the hands of the plan, the plan did not initially pay the claims, and the only tool CMS was able to use was writing threatening letters to the already-terminated plan.

CMS was actively involved in the case, yet felt they had no leverage over the plan since it had already been terminated from Part D. As a result, CMS advised us to work directly with the plan. This was an unfortunate situation, given that the government had already prepaid the plan for these claims with taxpayers' funds, which the terminated plan was holding. While we appreciate that the claims were finally paid, we believe that this type of situation needs to be addressed in any expansion of fraud, waste and abuse legislation to protect the taxpayers and the Federal government from similar situations.

With respect to pharmacy fraud, we obviously believe that truly fraudulent pharmacies should be kicked out of Federal programs. At the same time, we are also concerned that law-abiding pharmacies are being targeted by PBMs for auditing that has little or nothing to do with fraud but everything to do with padding profits. As the OIG exclusions lists will tell you, only 0.2%¹¹ of all excluded providers are pharmacies, which is an indicator of the extremely low risk of fraud in our sector. Unfortunately, instead of focusing on detecting and deterring fraud, PBMs have been focusing their resources harassing law-abiding pharmacies to find non-substantive technical issues on which to base denials of claims and to recoup funds.

¹¹ Compiled using data from the United States Department of Health & Human Services, Office of Inspector General, List of Excluded Individuals/Entities.

To be clear, NCPA understands the necessity for appropriate auditing of all health care providers, including pharmacies. NCPA does not advocate for any provider having the ability to retain reimbursement for claims for which payment is not permitted under the relevant law, regulation or contract. Many PBM audits, however, are not legitimate audits. These PBM audits are nothing more than fishing expeditions by PBMs to find hyper-technical issues on which to deny payment even when the claim is otherwise allowable, legitimate and appropriate. For example, we hear multiple examples of PBMs recouping tens of thousands of dollars in prescription claims for legally-valid and appropriate prescriptions for mere technical issues such as a case in which a pharmacist placed a sticker on the back of the prescription rather than the front. Here are some typical examples from a community pharmacy:

- *A doctor changed the amount of refills on a written prescription without initialing it. The auditor requested \$1,700 back from us – the full cost of the drug plus our dispensing costs. In protest, the physician wrote a letter affirming that it was her handwriting and that she did indeed want those refills for the patient. The auditor would not accept this and we appealed again. The physician wrote another letter but it was also refused. It's too expensive for a small pharmacy like ours to fight with a lawyer, so we're forced to pay the \$1,700, not to mention the lost hours contesting this.*
- *Another doctor prescribed a specific strength of Seroquel. The doctor had to retrace the prescription because his handwriting is a little shaky. The auditor accused us of altering the prescription and attempted to invalidate it. Again, the doctor and pharmacist have to take time away from patients to affirm the prescription's legitimacy.*
- *One minor, clerical mistake was met with a \$6,000 penalty. We adjudicated the claim mistakenly with the wrong doctor's name. The doctor was in the same practice as the prescribing physician, and had also seen this patient the month before, but did not write the prescription on this occasion. The audit company refused all explanations, including letters from both doctors. Finally, we appealed to the insurance company. Within 24 hours they called us back and had manually changed the doctors in their system to reflect the correction.*

These practices are inappropriate and do nothing to serve beneficiaries or reduce actual fraudulent activities in the program. Instead, these are out of control efforts by PBMs designed to recoup funds for legitimate prescriptions. Again, NCPA agrees that audits are necessary to protect the integrity of the program and to recoup any reimbursement amount that is erroneous or improper. But, the current state of PBM audits far exceeds those boundaries and is resulting in the recoupment of legitimate reimbursement amounts. For that reason, we believe that there should be more standardization on how PBMs audit under Federal programs, what issues may be legitimately subject to audit, and how pharmacies may appeal decisions and receive appropriate and prompt adjudication of these claims. This will help assure that these audit activities will be properly focused on truly going after the “bad actors”, not technical administrative issues that have nothing to do with fraud. Finally, we wonder whether PBMs audit the same mail order pharmacies *that they own* as aggressively as they do small independent pharmacies – their competitors. Policies permitting PBMs to harass small community pharmacies should stop.

Recognize Wastefulness of Mail Order

PBMs want payers to think that mail-order saves because the PBMs earn (and in many cases keep) significant manufacturer rebates from the large quantities of expensive brand name medications that they push through mail order. At the end of the day, however, these rebates may or may not be passed through to payers. Moreover, PBMs repackaging medications under their own label, assign them a higher cost basis, and then make it appear that they are still giving a higher discount on mail order prescriptions. Finally, no amount of manufacturer rebates paid on a brand name drug can make a prescription less costly than if a generic is dispensed.

Community pharmacies do a much better job at dispensing generics because we don't have the perverse incentives that PBMs have to push brand name drugs through mail order outlets in order to collect lucrative rebates. The higher generic dispensing rate at retail pharmacies compared to mail-order demonstrate that retail pharmacy is much more effective at promoting generic drugs than mail order pharmacies, which results in significant savings. NCPA believes that Congress should enact legislation which stems the tidal wave in existing prescription drug payment policies that push drugs through the mail order channel to the exclusion of retail pharmacies and perversely promotes expensive brand name drugs over generic drugs.

The TRICARE program is attempting to encourage more mail order use, even though TRICARE mail order contractor only dispenses generic drugs just over 50 percent of the time.¹² This is at least 10 percentage points lower than even other mail order programs, where the generic dispensing rate is already low. Compare this to the fact that retail pharmacies in the TRICARE retail pharmacy network dispense generic drugs over 70% of the time.¹³ TRICARE should undertake a beneficiary-focused education initiative to increase the utilization of generic drugs through retail pharmacies rather than sending them to the mail order pharmacy.

Better Management of Patients' Drug Therapy

As much as \$290 billion¹⁴ is spent on health care each year due to medications that are either not used appropriately or patients not taking their medications as prescribed. Lack of adherence with medications for chronic conditions, such as high blood pressure or high cholesterol, is a major cause of readmissions to hospitals. Pharmacists, working with prescribers, can help improve the use of medications through counseling, adherence and medication therapy management programs. Community based pharmacists can have the most significant impact because of the personal, face to face education that we can provide and because we can monitor our patients when we see them in the pharmacy.

¹² Based on statistics provided to NCPA by the TRICARE Pharmacy Program.

¹³ *Id.*

¹⁴ New England Healthcare Institute, *Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease*, 2009.

Given the costs associated with poor medication adherence and the potential savings to be generated through medication therapy management, NCPA urges Congress to pass S. 274, The Medication Therapy Management Empowerment Act of 2011. This proposed legislation will provide more coverage for and greater access to MTM services provided by community pharmacies, encourages preventive care among Medicare Part D beneficiaries and improves medication adherence by Medicare Part D beneficiaries. The end result is that more investment in MTM services reaps long term savings by avoiding costly health care interventions and hospitalizations.

Reduce Waste in Medicare Part B Diabetes Testing Supplies

Medicare Part B pays for billions of dollars each year in diabetes test strips – the majority of which are dispensed through mail order. These strips help beneficiaries maintain proper glucose levels. Yet, community pharmacists continually hear stories from patients about how the mail order company continues to send test strips to the beneficiary, even if they don't need them. Some patients indicate they have closets full of these strips.

This means that either the mail order company is disregarding “stop orders” and has placed the person on automatic renewal even if they don't need the test strips or the person is not testing correctly, which could lead to further diabetes complications. This is a lose-lose situation for Medicare and for beneficiaries with diabetes. Medicare pays for test strips that aren't needed, while patients are not being managed well because they are getting their test strips from a mail order firm rather than being managed by their community pharmacist.

Given the costs and waste associated with mail order diabetic testing supplies, NCPA believes that Congress should pass H.R. 1936, the Medicare Diabetes Access to Care Act. This bill will preserve and ensure Medicare beneficiaries' access to community pharmacy diabetic testing supplies and the all-important face-to-face counseling that they receive from their community pharmacies. Such counseling and monitoring will improve diabetes testing adherence avoiding long run costly diabetes complications.

Conclusion

NCPA and its small business owner members remain committed to combating waste, fraud and abuse within federal healthcare programs, and stands at the ready to assist with these efforts. NCPA and community pharmacies seek to partner with the federal government in generating health care savings, while providing high quality health care to our patients. However, NCPA has concerns about misperceptions regarding the false savings associated with PBMs and mail order pharmacy. To summarize, community pharmacy maintains that passage of the proposed legislation referenced above and focusing on the issues outlined will generate more savings and eliminate more waste from federal healthcare programs than alternative than use mail order as their central tenet. Thank you for the opportunity to submit this statement.

