

PRESIDENT'S FISCAL YEAR 2010 HEALTH CARE PROPOSALS

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

MARCH 10, 2009



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PRESIDENT'S FISCAL YEAR 2010 HEALTH CARE PROPOSALS

TUESDAY, MARCH 10, 2009

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

The hearing was convened, pursuant to notice, at 10:04 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Carper, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, and Enzi.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Elizabeth Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Yvette Fontenot, Professional Staff; Shawn Bishop, Professional Staff; and Chris Dawe, Professional Staff. Republican Staff: Rodney Whitlock, Health Policy Advisor; Andrew McKechnie, Health Policy Advisor; and Jim Lyons, Tax Counsel.

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

The CHAIRMAN. The committee will come to order.

On February 24th, President Obama said, "Nearly a century after Teddy Roosevelt first called for reform, the cost of our health care has weighed down our economy and the conscience long enough. So let there be no doubt: health care reform cannot wait, it must not wait, and it will not wait another year."

I could not agree more with our President. Our next objective is health care reform. Comprehensive health reform is no longer simply an option, it is an imperative. If we delayed, the problems that we face today would grow even worse. If we delayed, millions more Americans would lose their coverage. If we delayed, premiums would rise even further out of reach. And, if we delayed, Federal health care spending would soak up an even greater share of our Nation's income.

Senator Grassley and I have laid out a schedule to do just that. Our schedule calls for the committee to mark up a comprehensive health care reform bill in June. We should put a health care bill on the President's desk this summer.

The President's budget makes a historic down payment on health care reform. Over the next 10 years, the President's budget invests \$634 billion to reform our health care system. Reforming health care means making coverage affordable over the long run, it means

improving the quality of care, and it means expanding health insurance to cover all Americans.

Given our current economic situation, this becomes more important than ever. According to the Center on Economic Progress, the number of uninsured people grows by 14,000 every day. We need fundamental reform in cost, in quality, and in coverage. We need to address all three objectives at the same time. They are interconnected. If you do not address them together, you will never really address any of them alone.

Costs grow too rapidly because the system pays for volume, not quality. Quality indicators like lifespan and infant mortality remain low because too many are left out of the system. Families do not get coverage because health costs grow faster than wages. Without coverage, health insurance costs increase because providers shift the cost of uncompensated care to paying customers. It is a vicious cycle; each problem feeds on the others. We need a comprehensive response.

Today it is my pleasure to welcome the Director of the Office of Management and Budget, Peter Orszag, to discuss the health care proposals in the President's budget. Peter and I have met many times to talk about health care reform. He is one of the brightest and hardest-working folks in the administration, and we all appreciate him very much.

Today we will explore the President's proposals to help offset the cost of health care reform, and today we will also explore any feasible proposals that the administration has left out. Our goal is to offset the cost of health care reform, so we need to think creatively about proposals that will both improve quality and reduce the growth of health care costs in a 10-year budget window.

As Dr. Orszag has said, the path to fiscal responsibility must run directly through health care. Our country's economic sustainability depends on health care reform. I look forward to working with the administration toward that goal.

So let us, at long last, deliver on the dream of reform that Teddy Roosevelt called for nearly a century ago. Let us, at long last, lift the burden of health care costs on our economy and on the conscience of our Nation. Let us, at long last, enact health care reform this year.

Senator Grassley?

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. Thank you, Mr. Chairman.

The President released his budget last month and made it very clear that health care reform is a top priority. I share his commitment, and I am glad that we are taking a closer look at some of the health care reforms that are being proposed in this 2010 budget.

Health care reform is important, but it will not fix all the problems with our economy, nor will it solve the entitlement crisis. Fixing health care is necessary, but not sufficient. Still, we have a great opportunity before us, and it is an opportunity we are taking. The health care system, if you want to call it a system, is in desperate need of reforms. We spend twice as much on health care as

other developed nations, and even with all that spending our health care outcomes are often half as good. Millions live in fear of losing coverage, and 45 million do not have coverage.

Last week, Senator Baucus and I joined other members of Congress and various stakeholders at the White House forum. In bringing everybody together, it was clear that we agree on a lot of issues, and yet still have a long ways to go on others. But overall, I left the White House knowing that Republicans and Democrats share a commitment to expanding health insurance and improving the way care is paid for and delivered in the country.

On the same day as the White House forum, Senator Baucus and I announced an ambitious, but I think achievable, schedule for developing bipartisan health reform proposals. I feel positive about how we are starting this process. Let me also say that we have a long ways to go, and there is a lot of heavy lifting.

At this point, I have not heard from any Republican Senators that we should not be working on health care reform this year. We have not had to make any difficult decisions yet, but no one has said to me that we should not be trying to pass health care reform.

Right now, Republicans and Democrats are able to agree on a variety of broad issues, but the true test of this bipartisan process will be how we handle those details, particularly the few tough details to work out. I do believe that by working together we can face this challenge and get the job done.

So that brings me to today's topic, the President's budget. The President's budget contains a number of bold proposals that interest me. However, it was also lacking in detail, so I hope to have you, Dr. Orszag, today, shed some light on details of this budget proposal, how the administration will approach health reform.

We all see the Nation's fiscal situation getting worse by the day. The current administration inherited a \$1-trillion deficit, and they promptly added another \$1 trillion to our National debt with the economic stimulus bill. The stock market has fallen another 20 percent just since the President took office.

Now the Obama administration is proposing a \$634-billion health reform reserve fund which they say is merely a "down payment." While fixing our health care system has to be a priority, so is financing it responsibly. We have an obligation to make sure that any changes we are considering in health care are financed and developed responsibly so that we do not make the situation worse.

We must be very wary of the idea that we have to spend more up front to reap savings down the road. I am not saying that that is totally wrong, but too much emphasis on that can be misleading. Too often with the Federal Government, the up-front spending happens, but I have seen long-term savings never materialize.

In his former position, our witness, Dr. Orszag, at CBO, was clear about the reforms that reduce costs and the ones that do not. As we consider the President's proposal and move forward on health reform, I hope that we can all maintain that clarity. If done correctly, prevention and health IT proposals can improve this system, but CBO has been very clear that they are not the cost-savers that some would think.

As for specific reforms in the budget proposal, I was pleased to see a commitment to delivery system reforms. We need to change how we pay for services with Medicare, making it more efficient, rewarding quality, and reducing waste, fraud, and abuse. The President has also proposed changes in Medicare Advantage. While there are very few details at this point, I have serious concerns about the level of proposed cuts and the rate at which those cuts go into effect.

A competitive bidding proposal may be an effective way to increase competition in Medicare Advantage and reduce overall spending, but I believe, if it is not done carefully, it can do harm to choice that we want to have for our seniors. I cannot support a proposal that will ultimately jeopardize coverage of the 10 million current enrollees, or limit access for future Medicare beneficiaries. If almost all of Iowa's seniors lose their Medicare coverage that they have now or lose their ability to choose their own plan in a so-called reform, we will not have done a good job.

As Congress considers the President's budget and broader health reform efforts, I hope Republicans and Democrats can agree on four principles. First, health reform should be done through regular order, not reconciliation, and be done in a fiscally responsible manner. The schedule and process that Chairman Baucus and I have developed would follow regular order, and so we are off to a very good start in that regard.

Second, next, our top priority should be to bring health care costs under control. We must provide affordable coverage to 45 million uninsured, but it does not do anyone any good if Congress expands coverage but does not address out-of-control health care costs.

Third, we must also uphold the promise that, if you like the coverage you have, you ought to be able to keep it. President Obama made this promise time and time again during the campaign, and we owe it to Americans to make sure that we all help him keep that promise.

Fourth, and last, whatever changes Congress makes to our health care system, we must ensure that, at the end of the day, health care decisions are made by two people, the patient and the doctor. I support making sure that patients and doctors have up-to-date and effective information, but I would not support reforms that allow some government bureaucrat to interfere with a doctor's ability to practice medicine. We should not put the government in charge of your health care decision about what doctor you might want to go to and what treatments that doctor might suggest.

Dr. Orszag, thank you for coming. I hope to hear some rebuttal to my suggestions, as well as answers to my questions.

The CHAIRMAN. Thank you, Senator. Thank you very much.

Our witness today is a regular, Dr. Peter Orszag, only this time in the capacity of Director of the Office of Management and Budget.

As a member of our frequent witness program, Dr. Orszag, we very much appreciate your being here again. As you know, your prepared statement will be included in the record, and I would urge you to proceed.

**STATEMENT OF HON. PETER ORSZAG, DIRECTOR, OFFICE OF
MANAGEMENT AND BUDGET, WASHINGTON, DC**

Dr. ORSZAG. Thank you very much, Mr. Chairman, Senator Grassley, members of the committee.

"The link between health care costs and the economy is undeniable. In 2009, Congress must take up and act on meaningful health reform legislation that achieves coverage for every American, while also addressing the underlying problems in our health system. The urgency of this task has become undeniable." Those are not my words, those are direct quotations from the document that the Senate Finance Committee put together last fall, and I would just say "amen."

Building on the health forum that we held last week—and I thank the chairman, ranking member, and other members of the committee who participated in that—at which there was strong bipartisan support for getting health reform done this year, I am looking forward to working with all of you to accomplish that goal of leading to a more efficient health care system, expanding coverage, improving quality, and bringing down costs.

The President has announced his intention to nominate Governor Sebelius as Secretary of HHS. My understanding is that she will be up visiting with Senators this week, and I hope and urge that the Senate will confirm her quickly so that we have the Secretary in place as we begin this process.

In addition to that, Nancy-Ann DeParle, who is the White House Coordinator on Health Reform, will be up meeting with you and your staffs this week to begin the process of working with you on legislation to get health reform done this year.

On that, let me just note immediately, so that perhaps we can avoid the typical Washington game of "gotcha," that the administration has been very clear. We have put a significant down payment on the table, but with regard to benefits and coverage, we want to leave everything on the table at this point to allow the process to play out. So you should not expect, and you will not be receiving, definitive answers from me on exactly what the administration does or does not favor on the benefits and coverage side of health reform.

As is now, I think, well appreciated, health care costs are the key to our fiscal future. You have a packet in front of you. Slide 4 (p. 66) shows projections of Medicare and Medicaid, Social Security, and other parts of overall government spending. Just to pick up on something that Senator Grassley said, it is clear that there are long-term fiscal problems in Social Security and in the rest of the government. But if you look at that graph, it is also clear that those two health programs are absolutely core to our long-term fiscal difficulties. I think it is undeniable, based on that graph, that health care reform is entitlement reform, simply looking at the numbers.

Health care reform, though, is not just a long-term problem. There is a more immediate saliency to it. Health care costs are reducing workers' take-home pay today to a degree that is unnecessarily large, and perhaps under-appreciated. Health care costs today are crowding out other priorities for State governments, including support for higher education.

Your taxpayer dollars today are financing variations in Medicare costs across different parts of the United States, across hospitals within a region, and across doctors within a hospital that do not seem to correspond to better outcomes and higher quality for the higher-cost approaches.

I have shown this graph repeatedly before this committee, but on page 6 of your packet you have that variation in health care costs across the United States. It is just worth emphasizing over and over and over again, we have such substantial variation across different parts of the United States that cannot be explained by how sick the patients are in the higher-cost areas, by the cost of building a hospital, by doctors' salaries.

The explanation is that, in those parts of the country with higher costs, there are more procedures done, more days in hospital, more tests and what have you, none of which seems to actually improve health outcomes. That is the key take-away. If you look at outcomes and quality, the higher-cost States, the higher-cost hospitals, the higher-cost doctors do not produce better outcomes than the more efficient providers.

Researchers at Dartmouth College have taken these data and suggested that, if we can move the practice norms in the darker-colored parts of the country towards those in the lighter parts of the country, we could reduce health care costs by \$700 billion a year without harming health outcomes. There is nothing else that even comes close in terms of opportunities to improve the efficiency of our economy.

Now, what are we doing to capture that opportunity? Several things. First, the Recovery Act was the most aggressive movement towards universal health information technology in the history of this country. It includes \$19 billion to put us on a path of universal health IT.

Second, the Recovery Act also provides funding for an expanded comparative effectiveness effort so that your doctor and your hospital have more information about what works and what does not in recommending treatments to you.

Third, we need to reform the financial incentives facing providers. Currently, we have incentives for more care rather than better care, and that is exactly what we get. The budget includes significant changes that will create stronger incentives for better care; a hospital quality incentive program so that hospitals will pay for better care rather than more; penalties for high readmission rates, because 18 percent of Medicare beneficiaries are readmitted to a hospital within 1 month after being discharged, many of which are unnecessary, both driving up costs and harming beneficiaries. Who wants to go back into the hospital right after being discharged, without it being necessary? Incentives for doctors, bonus-eligible organizations so that doctors have stronger incentives to provide higher quality care—I could continue. We also invest in prevention and wellness. The Recovery Act provides \$1 billion for a historic effort at improving prevention and wellness.

All in all, the budget provides \$634 billion in the down payment to begin the process of health care reform this year, to expand coverage, reduce costs, and lead to a more efficient health care system. I, and the rest of the administration team, looks forward to work-

ing with this committee and other policymakers to get this done this year.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Orszag, very much.

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

The CHAIRMAN. Could you just tell us what the cost of doing nothing is? Life is alternatives. You do something, or you do something else, you do nothing. It is alternatives, it is choices. What is the cost of doing nothing?

Dr. ORSZAG. The cost of doing nothing is a fiscal trajectory that will lead to a fiscal crisis over time. The cost of doing nothing is perpetuating a system in which workers' take-home pay is unnecessarily reduced because of an inefficient health care system. The cost of doing nothing is 46 million uninsured people who do not receive adequate health care.

The cost of doing nothing is a burden on State governments that is causing lots of unanticipated effects. For example, lots of families are experiencing higher tuition at public universities. Research very clearly connects those higher tuitions to rising costs for health care in State government budgets, which then means they do not have room to support public higher education to the degree they did in the past.

In area after area after area, we see excessively high health care costs burdening workers, State governments, and the Federal Government. I am going to come back again: Dartmouth College, a \$700-billion opportunity to reduce health care costs without harming quality. How can we perpetuate a system that contains that large an inefficiency?

The CHAIRMAN. Now, based upon the Dartmouth College analysis, which many of us point to and which is very graphic, as you have demonstrated, if you could prioritize one, two, or three actions that this Congress, you think, could take to help address that disparity. As you point out when you, in an earlier life, were at CBO, I think it is a 29-percent geographic disparity. As you say, it is about \$700 billion.

Prioritize one, two, or three items that you think the Congress should take to start to address that disparity, recognizing there are politics here. Some of the States that are getting a lot of money are not going to want to give it up, but we have to figure out a way where we are working together to prevent that disparity.

Dr. ORSZAG. I think this budget and what you have already signed into law is the most aggressive set of steps to try to capture that \$700 billion that the Congressional Budget Office, the Institute of Medicine, and others have come up with.

Let me be more specific. Too much of the medical care delivered in the United States is not backed by specific medical evidence that it works better than an alternative. Take prostate cancer, for example. We have dramatically different ways of treating prostate cancer, from proton-beam treatments to other interventions. There is no evidence that exists on what the benefits are relative to how much that is costing us for the different kinds of treatment.

In different areas, there are just different norms. Sometimes proton-beam treatment is much more likely or much more prevalent; in other areas, not so much. To get at that, we need much

more information not only on what is done to a patient, which we already have through insurance claims, but what the result is, what happens to your blood pressure, and your cholesterol, and what have you, so that your doctor can then have more information about effective interventions.

The CHAIRMAN. You are talking about evidence-based medicine.

Dr. ORSZAG. Evidence-based medicine. Yes, sir.

The CHAIRMAN. You are talking about that. So how do we get the evidence?

Dr. ORSZAG. We get the evidence by moving the health sector to something that has been pervasive throughout the rest of our economy, but the health system has lagged behind, which is, information technology. It is stunning that in health care, unlike other areas, we still have to, when we go to the doctor, fill out paper forms every time you go to see a new doctor.

The CHAIRMAN. But that is not evidence-based medicine.

Dr. ORSZAG. Well, no, but it is an input. It is necessary, but not sufficient. It is an input into evidence-based medicine.

The second thing we need to do is have the medical profession much more aggressively be examining what works and what does not. That is the comparative effectiveness effort. Then in addition, providers should not be penalized. It is stunning. Under our current system, providers are often financially penalized for doing the right thing, which is to say, delivering more efficient care. We have such strong incentives for more care that, if you deliver care more efficiently, you are often actually financially penalized rather than helped. That makes no sense.

The CHAIRMAN. Does it not take some time, though, to get the evidence on which to have more of an evidence-based practice? Is there a data bank, is there a repository, is there something so that, when a doctor diagnoses a certain condition and he or she wants to go and look to see, what is the best evidence-based treatment here, in addition to, what does my gut tell me, what was I taught in medical school?

Dr. ORSZAG. Right.

The CHAIRMAN. So how do we get to the point where the doctor then has the availability to look—it is very significant evidence-based data.

Dr. ORSZAG. One of the other benefits of a health IT system is that, not only does it give more information about what works, it also provides a platform for the Institute of Medicine or other respected bodies to deliver best practice guidelines, or guideposts, back to practicing physicians.

So that, if I am sitting at my doctor's office and I have a problem, the doctor could immediately pull up not only the sort of recommendation from the medical profession on what works or what does not, but then, if he or she is interested, click through to the underlying evidence so that more of the recommendation is based on that evidence. Then not only that, but again, that doctor should not be financially penalized, but instead should be facing strong incentives for that best practice care. If we do not do that, we are coming back to perpetuating the system that exists.

The CHAIRMAN. I got you. Thank you. My time has expired.
Senator Grassley?

Senator GRASSLEY. Yes. Dr. Orszag, after I ask my first questions I am going to leave, but I want to come back for a second round, so I hope you will still be here.

Dr. ORSZAG. I will stay.

Senator GRASSLEY. All right.

On June 28, 2007, CBO's Economic and Budget Issue brief from your staff had this quote about Medicare Advantage cuts: "... would cause some plans to leave the program." The brief went on to say, "Rural areas would be affected more than urban ones." So, we have in this budget a cut of \$176 billion in Medicare Advantage through competitive bidding.

Question. If we take \$176 billion out of this Medicare Advantage program through planned bidding, how many of the 10 million beneficiaries enrolled in Medicare Advantage do you estimate would lose their current coverage? Also, how much of the \$176 billion in savings comes from decreased Medicare Advantage enrollment versus reduced payments to plans?

Dr. ORSZAG. I do not have the enrollment data, but let me again just step back and say two things. First, I know many people believe that capitalism is founded on private markets, and it is. But I very firmly believe that capitalism is not founded on excessively high subsidies to private firms. That is what this system delivers right now. For every Medicare beneficiary in Medicare Advantage, the Federal Government pays \$1,000 more than covering the same beneficiary under traditional fee-for-service.

In addition, it is true that Medicare Advantage plans then take part of that extra payment and deliver it in the form of either additional benefits or lower premiums to beneficiaries. But the data also suggest that every dollar of additional benefits costs the Federal Government \$1.30 in costs. So what we are doing is, we are all paying \$1.30 in order to deliver \$1.00 to a subset, 20 percent, of Medicare beneficiaries. I do not think that is competition, I think that is an unwarranted subsidy.

Senator GRASSLEY. Well, you are going to take half of my time lecturing me on capitalism.

Can you answer my question about how many of the 10 million beneficiaries enrolled, would you estimate, would lose? If you cannot give me a figure on the savings, how much comes from less enrollment versus less expenditures? At least tell me how many of the 10 million you think will go. Because in 2007, the agency that you headed at that time said that it would cause plans to leave the program and it would affect my area of the country, rural America, more than urban America. So I want to make sure, if we have a national system of health care, it is going to deliver the same thing in Iowa as it does in California, because for 40 years it did not.

Dr. ORSZAG. I do not have the enrollment figures with me. I would be happy to provide them in writing to you.

I would note two things. One is, this proposal is not the same as what was previously discussed by the Congressional Budget Office. We are not simply reducing payment rates administratively, but instead introducing competitive bidding, which is a different proposal and will have different regional effects. But I will get you the enrollment figures in writing.

I would note, even under the Congressional Budget Office projections, what the impact was, was there was dramatic growth in Medicare Advantage that was projected, and the proposal would reduce that growth, as opposed to reducing current enrollment.

Senator GRASSLEY. All right. I will await your written answer.

[The information appears in the appendix on p. 91.]

Senator GRASSLEY. In the 1 minute and 8 seconds I have left, maybe you can answer one question for me.

Dr. ORSZAG. Sure.

Senator GRASSLEY. We see a commitment to program integrity in the budget. Every dollar spent on program integrity ought to produce a return on investment. A challenge that we faced in the past was having CBO recognizing the savings that program integrity efforts and other legislative proposals produced because of scoring rules. Being former CBO Director, you are in a unique position now as OMB Director. The budget recognizes savings and mandatory spending from increased discretionary funding for program efforts. My question to you is whether CBO should, in fact, recognize these savings.

Dr. ORSZAG. I think the short answer is, the current scorekeeping rules, as you are aware, mean CBO does not recognize those savings, even though they are based on hard evidence that they would occur. It struck me when I was CBO Director, and it continues to strike me, that some revisiting of those rules would be warranted. So the group of scorekeepers that needs to get together to discuss the rules, I think that would be a good thing to do.

Senator GRASSLEY. Yes. My time is up, but I would ask the chairman if I could have maybe an extra minute on my second round because I was lectured on capitalism, and I studied that in economics.

The CHAIRMAN. Senator, why don't you take that minute right now?

Senator GRASSLEY. All right.

Dr. ORSZAG. No more lectures.

Senator GRASSLEY. During the campaign, President-elect Obama often promised that under his health care reform proposal, "If you've got a health plan you like, you can keep it." I am concerned this might not be true if we have a public plan paying government rates, competing with private insurers. I have heard some estimates, and I think they were from Lewin, that predict that 118 million people may lose their current coverage and 130 million will end up on government-run public plans.

Does President Obama intend to keep his promise that, if you like the coverage you have, you can keep it? Also, would he support a public plan that could crowd these 118 million out of the plan that he said they could keep if they wanted it?

Dr. ORSZAG. Senator, as I said at the beginning, we are trying at this point in the process to keep everything on the table. The President's campaign plan had a public option in it. There are obviously different ways of designing a public plan that would have different effects. One of the things that we would look forward to working with you on is, if there is a public plan, how to minimize some of the concerns that you have identified.

Senator GRASSLEY. All right. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I thought it was very interesting. The President, in various statements that he has made about health care policy, has said, \$634 billion. It is not going to do it all, but it is the best start we have ever had in history, and I want you in the Congress to figure it out. But he has also said, in sort of subclauses, that we are going to be watching very closely. I have a health care plan that I care about. The idea is, if we do not come up and do the job right, he has plenty of people who are willing to step in and exercise judgment and muscle.

Question. Two questions. One is, how do you coordinate Federal efforts to define quality? I mean, you have the Agency for Health Care Research and Quality, you have the National Quality Forum. CMS—that is, Medicare and Medicaid—has Quality Improvement Organizations, the QIOs. There are a variety of ways, plus all of our judgments and all the rest of it. How does this get defined on a Federal basis?

Dr. ORSZAG. Well, Senator, I think, as you, Senator Baucus, and others have pointed out, one of the issues is the process through which many of these things occur currently. I know you have an idea with regard to strengthening MedPAC. Senator Baucus has ideas on a Health Institute. One of the roles that such a body could play is to coordinate more strongly the various different quality indicators and quality efforts that are currently under way.

Senator ROCKEFELLER. So using those and others as advisory approaches.

Dr. ORSZAG. Correct. There are a lot of efforts under way. I should say, a lot of progress has been made to better measure quality. For example, the Premier Program for Hospitals under Medicare has shown to be effective in improving quality in hospitals. That is just one example. There have been a variety of examples in which we are moving towards higher quality, but we are not where we need to be.

Senator ROCKEFELLER. The second question is what you have already mentioned. That is, it has always bothered me, in the system of lobbying that we have in this country, and particularly on this subject—I do not know how many thousands of health care lobbyists there are. I think there were 14,000 at the end of the Clinton effort; higher-paid, more niche-oriented now. So you get these heads of all these huge organizations saying, we are going to be different. We are going to be different. We are going to cooperate this time, which I guess means that their lobbyists will stop lobbying and they will just rely on the facts. I think that the best way to take politics out of all of this is to take Congress out of the setting of reimbursement for doctors under Medicare and Medicaid, and for hospitals, because those are a group of 17—it could be whatever number—completely dispassionate people. I think one of the major problems you have in your \$700 billion of wasted money every year is the fact that there are too many political judgments made, be-

cause there is too much lobbying. Congress, unless they are all health care experts, can fall victim to that.

So the idea of MedPAC having the power to set those fees, reimbursement fees, to me is enormously attractive. It takes politics right out of it and takes Congress right out of it. Thoughts?

Dr. ORSZAG. Well, as I said, I think there are changes to the current process that would be beneficial in terms of moving towards a more efficient health care system. Your idea of, I think we have referred to it as MedPAC on steroids, or a much more powerful role for a body that is widely respected, is one approach. A related approach is the one that Senator Baucus has put forward. You mentioned some of the outside groups. I just came from America's Health Insurance Plans' annual meeting. They have an idea that is similar also.

So one of the things that I am hoping that we can explore, as legislation is put forward this year, is whether some change in the process could again help to improve decision-making for the reasons that you specified.

Senator ROCKEFELLER. Mr. Chairman, let me just end with one thought. Along with what I suggested about MedPAC, you would then have to get substantial amounts of new money in order to do the research that they will need to do, because right now they have no authority to do anything. CMS has all the authority.

Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Wyden, you are next.

Senator WYDEN. Thank you very much, Mr. Chairman.

Dr. Orszag, few people inside or outside government have dug more thoroughly into this subject than you, and I think that is why you are getting the tough questions, and we appreciate your being here.

Here is my take on where things are. With the economy sucking hundreds of billions of dollars out for these bailouts, Americans want to know why the \$2.5 trillion that is sloshing around this year in American health care should not be spent more efficiently first before you go to talking about hundreds of billions of dollars of new taxes in order to fund health care reform. So what I want to ask you about are three significant cost savers for either individuals or government that you can get out of the \$2.5 trillion that is being spent today.

The first is insurance market reform. The system is broken. It is all about cherry-picking and just taking healthy people, sending sick people over to government programs more fragile than they are. The people who are really getting clobbered are the 17 million in the individual insurance market. We have to find a way to get them into bigger groups so they have some clout. That is cost-saver number one out of \$2.5 trillion.

The second big cost-saver involves these tax rules. They are the third biggest program in American government today. They are regressive. Making them progressive will help our people now, and it uses existing money.

The third involves personal responsibility. Over 10 million people in this country with incomes over \$60,000 a year are uninsured, and it seems to me there ought to be some personal responsibility

rather than just having all these inappropriate emergency room visits.

So my question to you is, you have talked about everything on the table. If we can get those three significant cost-savers for individuals or for government in a Baucus-Grassley bipartisan health reform package, are you going to object?

Dr. ORSZAG. Again, at this point, I think everything, including those three, most firmly, should remain on the table.

Senator WYDEN. What else should we be doing to get them off the table and into the bill?

Dr. ORSZAG. That is up to you.

Senator WYDEN. I have outlined three areas. They are in Senator Baucus's white paper. They are ones that have bipartisan support. We have Senators of both political parties in favor of them. I think what the country wants to see is getting these savings out of the system today first before you start talking about new money, particularly new money that comes from taxes unrelated to health care.

So what else can you say about getting savings out of the system first before you go to new money?

Dr. ORSZAG. Well, let me again say there are significant savings to be had. The Dartmouth College numbers perhaps are the most dramatic example of the opportunity. But in general, capturing at least part of those savings, or all of them, or some of them, is going to take some time. We talked before about the practice variation that exists across regions, across hospitals, across doctors. It is not going to change like that.

Senator WYDEN. But that is why the savings that I pointed out are savings you can get next year, if we get them in legislation that has White House support. So I am not going to prolong this, but I hope that you are going to support those three major cost-savers for individuals and government, because you get those savings quickly, you help the American people, and it is not going to be credible to go on out and ask for hundreds of billions of dollars more without first showing you are getting the savings that are in the system.

The second area I want to ask you about, quickly, is the employer-based system. The White House, to its credit, has said it wants people to be able to keep the coverage they have, while helping to promote portability, which I think is absolutely key. The typical worker changes their job, now, 11 times by the time they are 40. With all these layoffs, it is becoming even more important.

How would you envision people being able to keep the coverage they have, while making health coverage in this country more portable?

Dr. ORSZAG. Well, there are lots of different approaches for doing that. I know that you and Mr. Bennett have an approach that would accomplish that; the chairman, in the white paper, has another approach.

One point worth making about employer-sponsored insurance is, there is often a concern about crowding out. That is, as you add other insurance options, do employers drop or scale back their offering? If you look at the Massachusetts experience, instead of crowding out there was actually crowding in. That is to say,

employer-sponsored insurance actually went up after Massachusetts reformed its system, which would be the opposite of what you would predict. I think the reason is, workers went to their firms and said, you know what? I really think we would like health insurance through you, and more health insurance was delivered through employers as a result.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Roberts? Are you going to ask about TO?

Senator ROBERTS. I beg your pardon, sir?

The CHAIRMAN. Are you going to ask about TO?

Senator ROBERTS. No, that was the Trade Representative.

The CHAIRMAN. Oh, that was his question?

Senator ROBERTS. That was Secretary Kirk, who I wished to ask if the trade of TO to Buffalo was a wise one on behalf of our trade interests in the United States. But obviously from the response from the public, they do not know what I am talking about. [Laughter.]

The CHAIRMAN. It is a health care group.

Senator ROBERTS. Please do not take this out of my time. This was your question. [Laughter.]

The CHAIRMAN. The clock has not even started.

Senator ROBERTS. Turn it back on five.

The CHAIRMAN. There we go. You are on five.

Senator ROBERTS. Peter, thank you very much for coming. Thank you for the job that you do.

I have one question, and the answer is yes. [Laughter.] According to the President's budget proposal, there appears to be support efforts to allow Americans to buy drugs from other countries. You know all about that. Tremendous populist move in the Congress. I understand that.

But last year, contaminated blood thinner from China caused hundreds of Americans to have allergic reactions, and some deaths. The World Health Organization noted that drug counterfeiting is now a \$32-billion-a-year business, and growing rapidly. As the former chairman of the Senate Intelligence Committee, Senator Rockefeller probably shares the same concern. This is very concerning for me. If any one country wanted to launch a particular attack in a particular area, this would be a powerful way to do it.

Would you agree that, before we move forward with any proposal to allow Americans to buy drugs from other countries, we certainly also must demonstrate that we can do so safely, without increasing the chances that Americans may get a contaminated or potentially dangerous or counterfeit medication? Would you also agree that, if such a proposal were to move forward, we should demand that any drug imported into the U.S. meet the same high safety and efficacy standards of our FDA, including bio-equivalency standards?

Dr. ORSZAG. Yes.

Senator ROBERTS. Thank you.

Dr. ORSZAG. Obviously there are different ways of valuing that.

Senator ROBERTS. Yes. I understand that. I understand that. I just want to say that I hope that Congress stays involved. Senator Rockefeller wants to turn it over to a different group that hopefully would shine the light of truth into competitive darkness. But if it

was not for this committee putting off for 18 months some of the Lizzie Borden cuts that CMS was making on virtually every provider in the health care providing world, it seems to me we would have had a much bigger problem of rationing health care and people dropping off the Medicare rolls because the medical profession simply would not do that.

I have heard that in April the administration is likely to spell out the fact that they intend to give CMS least-costly alternative authority—the acronym for that now is LCA—which would essentially give CMS the ability to pay only for the least-costly alternative product within a specific product category.

CMS has done this with durable medical equipment for years, but when they have tried to do it with drugs they were sued, and they lost the court decision. I am told reliably that the administration intends to give them clear LCA authority, and you can see how they might use this, basically deciding that a group of drugs, or two drugs, are similar and should be paid the same, or they should only pay for the cheaper one.

It gives CMS the authority to be the arbiter of clinical value, even though they have absolutely no expertise to make these kinds of judgments. The interplay between comparative effectiveness research—everybody on the committee ought to understand certainly comparative effectiveness research. That is the golden ring, that is the tablet coming down from Mt. CMS. The least-costly alternative authority is obvious. See here, our study can say that one product is better than another, and then CMS can invoke LCA authority to make the reimbursement decisions.

Will this not lead to continuing rationing of health care? How can we ensure that care, and not cost, is the only over-riding factor in comparative effectiveness research? How will CMS and FDA coordinate their efforts? I am very concerned about CMS replacing the FDA, which conducts some of the most rigorous clinical trials in the world, as the primary gatekeeper for medical drugs and devices.

Dr. ORSZAG. Well, let me comment on that final question first. One of the difficulties in the current system is the FDA testing is solely about safety and not about relative effectiveness compared to alternatives. So, for example, it is good to know that Drug A is safe relative to a placebo. It would be better to know how much more effective Drug A was compared to Drug B, and especially how much more effective Drug A was relative to other interventions, like surgery, or this or that. We do very little of that kind of comparison, and that is one of the things that comparative effectiveness research is intended to pursue.

Senator ROBERTS. Well, Peter, I understand that. It gets to better practices.

Dr. ORSZAG. Right.

Senator ROBERTS. You are going to have a design coming out from comparative research, the golden ring, and CMS, and issuing out to all of the doctors and all of the health care providers that they do this. But how can you really know this? Are all patients not different? There may be a situation where one doctor knows one patient, they tried a particular drug or a particular procedure

that did not fit in the better practices situation, and it takes away that decision from the patient and doctor.

In addition, if you do do the reimbursements in the way that I think that is going to be coming down, you are going to have many providers simply opting out. That is what has been happening out in our rural areas. That is what your map shows, that basically you have a pharmacist, a clinical lab, home health care provider, doctor, hospital, saying I am not serving Medicare any more.

Now, you are achieving a lot of cost savings that way, but you are leaving a lot of people out there without health care. I guess that would be my closing comment. I am over time. I apologize to my colleagues.

The CHAIRMAN. Thank you very much, Senator.

Dr. ORSZAG. Could you indulge me for 30 seconds?

The CHAIRMAN. Yes. Sure.

Dr. ORSZAG. Just very quickly.

The CHAIRMAN. Sure.

Dr. ORSZAG. Because I think this is crucially important.

The CHAIRMAN. It is. It is a very important subject, I agree. Go ahead.

Dr. ORSZAG. The intent of comparative effectiveness research is to allow your doctor and your hospital to have better information about what might help you. Obviously there has to be individual variation and idiosyncratic and sort of a one-on-one relationship with your doctor. But for me as a patient, I would like my doctor to have better information about what might help a middle-aged marathon-running male than he currently has. So one of the goals here is to expand the information base so that your doctor and your hospital have the information, that it may not be perfect, but it is better than currently exists. We often lack information about what works and what does not. I mean, a great example is prostate cancer. There are hugely different treatments.

The CHAIRMAN. Right.

Dr. ORSZAG. And we do not know which ones work better. I am sorry. Yes?

Senator ROBERTS. How about a middle-aged non-marathon running man? [Laughter.] Or a more mature? You get the drift?

Dr. ORSZAG. That is exactly the point.

Senator ROBERTS. The chairman has a bill on this, and he will emphasize health care as well as cost in the Lizzie Borden tactics by CMS. Pardon my bias.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman, and Dr. Orszag. It is always wonderful to see you here, and I appreciate your efforts and understanding of health care, and also your advocacy around health information technology, which I believe, as you know, is a critical part of this, as you have indicated.

First, let me just say more broadly, I think when we talk about, how do we get our arms around all of this in terms of health care, what makes this different than other areas of insurance is that you can choose not to get car insurance and not to have an automobile, you can choose not to have home insurance and not to buy a house. You cannot choose not to get sick. So whether you have health insurance or not, you will get sick anyway. So it creates a different

dimension that makes it, I think, difficult also to apply a strictly private sector model to this when you look at the fact that our choices as human beings do not include getting older, getting sick, and so on. So, it changes the dynamics for it.

On evidence-based practice, one area I just wanted to raise that we really have already started doing, is in the area of e-prescribing. Under the chairman's leadership, our work on the Medicare bill with e-prescribing goes, I believe, to more evidence-based practice. We have over 2,500 physicians in southeastern Michigan who have been doing a pilot, even before this, working with General Motors, the UAW, and Blue Cross and so on for e-prescribing, that has allowed them to get evidence.

Through the software package, we see the information. When they choose or decide to give someone a prescription, they see what else they are on. The program brings up whether or not there are allergic reactions between medicines, whether or not there is some other contraindication. The project in southeastern Michigan has shown that 30 percent of the time, based on evidence, based on information, the physician has actually changed the prescription. So that is just one example, I think, in a narrow sense of how we can make a difference, save money, save lives.

On prescription drugs, I want to commend you for talking about better access to generic drugs and the savings that come from there. I wondered if you might speak more to that. We have multiple agencies, HHS, FDA, FTC, dealing with a number of anti-competitiveness agreements between brand-name and generic companies.

I am wondering to what extent you have undertaken analysis up to this point on how much money would be saved, looking at a number of areas, whether it is authorized generics, what FDA is doing, the FTC, and so on, to really fully calculate what we might save as it relates to more competition through using generic drugs.

Dr. ORSZAG. Well, as one example, we do have almost \$20 billion in this health reserve fund that comes from more cost-effective delivery of pharmaceuticals. So that is obviously a significant part of the overall effort to capture the efficiencies in our health system.

Senator STABENOW. And have you made any determinations in terms of specific legislation that the administration will be supporting around any of the issues on generic drugs in order to get biologics to the marketplace, dealing with authorized generics, or closing loopholes as it relates to bringing generic drugs into the marketplace?

Dr. ORSZAG. Yes. And, in fact, as part of the reserve fund, we have a proposal for a follow-on biologic pathway to get approval, which we could discuss in more detail if you would like.

Senator STABENOW. All right.

Dr. ORSZAG. But it is included in the package.

Senator STABENOW. Thank you.

And, finally, I wonder if you might just speak for a moment on the question to which—when we look at international competitiveness or lack of competitiveness, having a number of global businesses in Michigan that provide health insurance to millions of people and seeing the lack of competitiveness, the loss of jobs that result from the inability to have a level playing field because we

fund health care differently than other countries. We spend twice as much as they do, and so on. Could you speak at all to that, as part of the economic challenge?

Dr. ORSZAG. Yes. Absolutely. Health care costs, again, are eating into workers' paychecks to a much greater degree here than abroad, and that is one of the forces that is weighing down on American families. I am going to come back again. That \$700 billion opportunity, even if you think the Dartmouth College estimates are too high by a factor of 2, so let us say it is only \$350 billion, that is a \$350-billion drag on our economy that is not improving health outcomes.

The CHAIRMAN. Senator Nelson?

Senator STABENOW. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator NELSON. Thank you, Mr. Chairman.

Dr. Orszag, I am curious where your proposal—one specific that you do mention is that you want to have the discount for Medicaid drugs increased from 15 to 22 percent. Now, that saves money. Why would you not want to have a similar discount for the purchase of drugs for the Medicare system? Not necessarily the same percentage.

Dr. ORSZAG. First, with regard to the Medicaid proposal, yes, we are proposing a movement from 15 to 22 percent of the average manufacturer's price. We also have some other changes, applying the discounts to managed care organizations within Medicaid.

With regard to Medicare, one of the things that perhaps could be discussed as part of overall health reform is changes to the prescription drug program as part of Medicare. We did not put forward a similar proposal for Medicare at this point, but I know that there is interest in that topic, and it is one of the things that we will be leaving on the table as we go forward. We were clear that the reform package that we put together was a down payment, but not the full deal in terms of health reform, and that more effort would be necessary. So we are eager for other people to come forward with their ideas, and I know that is one that many people have put forward.

Senator NELSON. Well, what is your opinion that negotiations to award a discount in Medicare under Part D could achieve savings?

Dr. ORSZAG. Well, it would depend on how it was done. If all that occurred was that authority was given to the Secretary to negotiate, the impact would depend on how aggressive the Secretary was in negotiations, and the Secretary may not have as much leverage as one would like. If, instead, an approach as is embodied in the Medicaid program was adopted, that would have more teeth to it, but the consequences in terms of the pharmaceutical market would also be more significant. So there are obviously different ways of doing it and trade-offs across the different options.

Senator NELSON. One, as you point out, is negotiations. Another is putting a discount into law. Well, on the issue of negotiations, what has been the experience of lowering the cost of drugs over the past couple of decades in the Veterans Department?

Dr. ORSZAG. The Veterans Administration has done a good job of obtaining pharmaceuticals in a cost-effective way. Now, that is for a few reasons. One is that they have access to the government's

best price system, as does Medicaid. Second, that they have a formulary, so that they do guide beneficiaries towards particular drugs and away from others, which helps them then negotiate better prices with the manufacturers.

Senator NELSON. Do most private health insurance plans have a formulary?

Dr. ORSZAG. Yes, sir.

Senator NELSON. The one thing that you did include, another specific recommendation in saving money, is to support efforts to buy drugs from other countries. Now, I have been—this particular Senator, because we have so many folks in my State who buy drugs from Canada who have been involved in this, I am curious as to what you think your savings would be with regard to the purchasing from other countries.

Dr. ORSZAG. What the budget includes is some money to begin the planning process for doing that, coming back to what I discussed with Senator Roberts. Obviously it needs to be done in a way that protects the safety of Americans. I think the evidence suggests that there are ways of doing that, but the savings will depend on exactly how it is done. This is the beginning of the process rather than the end.

Senator NELSON. All right. So this is just saying you would like to discuss that. You do not have a specific idea of savings?

Dr. ORSZAG. Correct. And more than just discuss it, that we think it is a good idea and we will be pursuing that path. We have funding to begin the process of fleshing out exactly how it could be done.

Senator NELSON. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Kyl, earlier, said to me that he would very much like to be here, but he has to attend another meeting.

After Senator Kyl, next is Senator Schumer.

Senator SCHUMER. Thank you, Mr. Chairman. Thank you, Dr. Orszag. I would like to follow up. Senator Stabenow, my colleague, was beginning to ask about biologics, biogenerics, and I would like to follow up on that. It is an issue that I have been active in for a while. It is a major priority.

Now, your folks estimated that the savings was \$9.2 billion over 10 years. Most people seemed to think that was a bit low, that there would be more savings than that, a little less than \$1 billion a year. Could you discuss those assumptions?

Dr. ORSZAG. Sure. The cost savings depend sensitively on not only the flow of biologic drugs and when they are coming off patent and what have you, but also things like the period of exclusivity that—

Senator SCHUMER. How much did you assume?

Dr. ORSZAG. Seven years.

Senator SCHUMER. Seven.

Dr. ORSZAG. So one possibility is that one could adjust that. You could tighten up on collateral settlements. There are a variety of other behaviors that affect cost savings that could be explored if you wanted to dial that up, but again, I want to just come back and say we went through a policy process. We thought this was the

best balancing of competing interests, and that is why it is included in the package in the form that you see.

Senator SCHUMER. Right now, of course, there is no generic competition, and so the biotech companies, understandably, price their drugs in a way that assumes no competition, which means basically, an economist would tell you, they charge monopoly prices indefinitely.

That is why I thought maybe your estimates were too high. Did you assume the price—not just the price—

Dr. ORSZAG. Too high or too low? Sorry. That our estimates were too high or too low?

Senator SCHUMER. Too low in terms of savings.

Dr. ORSZAG. All right. Right. Yes.

Senator SCHUMER. Too high in terms of how much they would charge.

I mean, again, 7-year exclusivity and only \$9.2 billion, that is about the most conservative estimate I have had. Did you assume that the price of most biologics would come down?

Dr. ORSZAG. Yes. I am sure we could get you more detailed information about the assumptions, but the evidence from the simple molecule market, where there already is generic competition, does suggest that, as drugs come off patent, prices come down significantly.

Senator SCHUMER. Right. Except the simple generic market. They know that is going to happen, and so they price it differently to try to preserve more market share and things like that.

Dr. ORSZAG. Correct.

Senator SCHUMER. I do not think that happens. I also do not believe you need a very long exclusivity period.

Now, let us say we did it 3 or 4 years, just to pick a number. How much more would the government save?

Dr. ORSZAG. I do not have a specific figure. I am sure we could provide estimates.

Senator SCHUMER. Would it about double, approximately? I am not asking you to—

Dr. ORSZAG. I do not—it is not necessarily linear or easy to figure out because it will depend on the flow of the current stock of biologics and when they are coming off patent, and what have you.

Senator SCHUMER. Right. And how about this: will a requirement for the FDA to publish guidance before a biogeneric can be improved significantly impact savings?

Dr. ORSZAG. Yes. One of the issues is the sort of evergreening process—

Senator SCHUMER. Yes.

Dr. ORSZAG [continuing]. Of reinventing the drug by slight modifications. So there are regulatory things that could constrain that and add to savings.

Senator SCHUMER. Yes. And how about this one: a requirement for biogenerics to have different names than the reference product. How does that impact savings? It makes therapeutic interchange more difficult, let alone interchangeability, right?

Dr. ORSZAG. That is correct.

Senator SCHUMER. So all of these things, if they were put in the bill, would cut back on our savings, if they were put in the law?

Dr. ORSZAG. Would increase?

Senator SCHUMER. Yes. Would increase our savings and cut back on the price.

Dr. ORSZAG. Yes. Correct. Correct.

Senator SCHUMER. All right.

My point here is that this is an area where there is bipartisan agreement in some of these. We had that last year. We are about to get that this year. I would just urge all of my colleagues, but the administration as well, to get as strong a biologic bill as possible, not only from the point of view of the consumer, which is the number-one reason—generics have saved us probably more money, the consumer more money and the government more money than just about any other medical change or advance, and we should do the same with biologics.

Can we have your cooperation in trying to get as strong a bill as possible?

Dr. ORSZAG. Absolutely. And let me just say, I mean, the reason we put forward what we did, there obviously are trade-offs. I know you are aware of this. One needs to balance the savings that you get against the incentives for the biologic drugs in the first place, and that is the balancing act reflected in our proposal. But clearly, other people may have alternatives.

Senator SCHUMER. Yes. And these companies are very, very profitable under present law, we know that.

The CHAIRMAN. Senator Bunning?

Senator BUNNING. Thank you, Mr. Chairman.

Since \$630 billion is the down payment for health care reform, how much more will you need?

Dr. ORSZAG. That will depend on the structure of benefits and coverage. There are different plans out there. I cannot give you a precise estimate because the plans vary. It depends on what is done. But under any of the proposals that are out there, whether it is the chairman's, or what the President spoke about in the campaign, or others that are floating around, it is clear this is a very substantial down payment.

Senator BUNNING. Substantial?

Dr. ORSZAG. Correct.

Senator BUNNING. In other words, half?

Dr. ORSZAG. I guess I do not want to sort of get in this game of—

Senator BUNNING. All right.

One of your suggested changes to Medicare is changing the way post-acute care is paid for. The budget suggests providing hospitals with a bundled payment for a patient's hospital-based care, and also any post-acute care they may need, like a rehabilitation hospital or long-term care hospital.

Can you give us more details about this? One, does a bundled payment mean that some of CMS's current payment policies, like the 75-percent rule for rehabilitation hospitals, still apply if hospitals get a bundled payment?

Dr. ORSZAG. I am told, again, the motivation here is to provide a more efficient system. That level of detail has not been determined. We would have to work with you as legislation is written.

Senator BUNNING. Neither one of those two things has any details, neither the bundled payment or the 75-percent rule? You have not got any details on either one?

Dr. ORSZAG. No, wait. So on the 75-percent rule, you mean with regard to readmission rates?

Senator BUNNING. No. I am talking about payment. Bundled payments.

Dr. ORSZAG. Right. That is a detail that we will need to work with you on as legislation is drafted.

Senator BUNNING. You have a cost saving in your budget document of almost \$18 billion for bundled payments for hospitals. You have to have some detail of how much you came up with to get to that number.

Dr. ORSZAG. That is correct. And again, we have a broad policy. In any policy proposal that you put forward, there is always going to be a super-structure and then there will be details. I am being told by the professional staff that we do not have a definitive answer to the 75-percent rule, and I am assuming, therefore, that it does not have a substantial effect on the score.

Senator BUNNING. In other words, the \$18 billion that you are saving?

Dr. ORSZAG. Again, I am being told that that is a technical detail and interaction that is not——

Senator BUNNING. Every year you do it in your budget document. Every year. So you have some experience that you are dealing with. This is not a guess.

Dr. ORSZAG. That is correct. One of the things that happens during a transition year is, we have 8 weeks to put together a document that normally takes 8 months. In April, there will be the full thing that you do not want to drop on your foot, and there will be more details provided at that point. I apologize, but I am being told that at this stage we do not have that degree of detail about this proposal.

Senator BUNNING. You cannot answer the question?

Dr. ORSZAG. I am sorry?

Senator BUNNING. You cannot answer the question?

Dr. ORSZAG. At this point I cannot answer the question.

Senator BUNNING. All right.

I have been very supportive of Medicare Advantage over the years because it gives the seniors in my State options for coverage. In the 120 counties in Kentucky, only 20 counties are covered by other than Medicare Advantage. So I have 100 counties that Medicare Advantage is the only Medicare that we can get. In the old Medicare+Choice program, the vast majority of counties in Kentucky did not have a managed care option under Medicare. These seniors could only use fee-for-service Medicare.

Your budget has proposed using competitive bidding in Medicare Advantage. What assurances can you give me that, should Congress change Medicare Advantage like you have suggested, beneficiaries in rural areas will have managed-care options under Medicare?

Dr. ORSZAG. Well, the whole theory of the case behind competitive bidding is that, if running a managed care or Medicare Advan-

tage plan is more expensive in rural areas than in urban areas, that will be reflected in the bids.

Senator BUNNING. So Medicare Advantage will still—

Dr. ORSZAG. This is not moving just to 100 percent of local fee-for-service. There is going to be variation.

Senator BUNNING. I would love to have the options in those 100 counties of something other than Medicare Advantage, but that is the only option these people have, fee-for-service or the Medicare Advantage.

Dr. ORSZAG. Right. Fee-for-service is still available.

Senator BUNNING. Oh, yes.

Dr. ORSZAG. And Medicare Advantage, under this competitive bidding—

Senator BUNNING. But you know, in fee-for-service and Medicare Advantage, there is quite a difference.

Dr. ORSZAG. Yes, sir.

Senator BUNNING. All right. I have 15 seconds.

Your budget recommends increases in the Medicare drug rebate from 15 to 22 percent.

Dr. ORSZAG. Correct.

Senator BUNNING. In a time when many drugs and biotech companies are facing tough economic times, what is your justification for increasing the rebate?

Dr. ORSZAG. A couple of things, sir. First, again, as was mentioned before—

Senator BUNNING. I heard.

Dr. ORSZAG. All right. Pharmaceutical costs are one of the most rapidly rising parts of the health care system. Medicaid already has this rebate, and we believe that more efficiencies are possible, which is why we proposed an increase.

Senator BUNNING. So we will have to wait until we see what the final plan is.

Dr. ORSZAG. No. There, it is very clear: we are increasing the rebate from 15 percent of average manufacturer price to 22 percent.

Senator BUNNING. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Thank you, Senator.

Senator Enzi, you are next.

Senator ENZI. Thank you, Mr. Chairman.

I had some other questions, but I want to go back to something that you were discussing with Senator Nelson. That is, the veterans' competitive bidding. Maybe it was—from your explanation, maybe it was comparative effectiveness, because you said that you were trying to channel people into specific drugs.

Does it not more than channel people into specific drugs? When we were doing Medicaid Part D, I was interested in having as many people in Wyoming signed up for it as possible, so I did a whole series of town meetings around senior citizens' homes. Invariably, at those I would have somebody who would show up and they would be really upset. They would say, under this I cannot get the drugs I want. All I had to say was, you are a veteran, are you not? They would say, yes, how did you know? I would say, well, Veterans does this competitive bidding process that eliminates things from the formulary. If you change to Medicare Part D, you

can get those. So, isn't this bidding process an elimination of some of the potential drugs that people can have?

Dr. ORSZAG. The way formularies work, both in VA and in many private health plans, is that there are a set of preferred drugs that are on the formulary. Non-preferred drugs are either not covered at all, or the beneficiary has to pay more for them. That is the way formularies work.

Senator ENZI. Yes. But it excludes veterans from getting what they want to have, but they can get it under Part D.

Nationwide, I am finding that people are not realizing what anything less than a half a trillion dollars is. That is just change. Even in Wyoming, I was disturbed to find that, because of the emphasis that we have placed on health care reform—and I am glad that we are placing that emphasis on health care reform—I have a significant number of people who think it is all going to be free, free not just to the poor, but free to the middle class as well. That is an impression that we are giving out there. Part of it is this \$634-billion reserve fund that we have that is not in the budget. Again, that gets above the level of change, because that is more than half a trillion dollars.

Then we say that it is just a down payment. That will probably help on that impression out there. But how did you come up with that exact number of \$634 billion? I assume it is from the chart that you have, I think it is on page 15, that actually shows \$633.8 billion.

Dr. ORSZAG. Yes. We rounded.

Senator ENZI. Those exact numbers, you rounded. I wish you would have rounded to \$700 or \$800 or \$500.

Dr. ORSZAG. Actually, on page 128 it is shown as \$633.759. [Laughter.]

Senator ENZI. I hope the calculations can be that exact, where it is kind of a guesstimate, is it not?

Dr. ORSZAG. Well, I guess there are two different questions. One is why, roughly, that level? Again, that was a judgment call. That was a very substantial down payment relative to any of the plans that are out there. Should it have been \$615 or \$645? Obviously there is variation, that that is possible.

Senator ENZI. Yes.

Dr. ORSZAG. I guess I will leave it at that.

Senator ENZI. I understand the difference between the budgeting and using all of the decimal places and everything, but in the statements that we are making to the public, when we use something as exacting as \$634 billion, they think that there is an exact proposal out there that will do something already. I would suspect that some of my colleagues think that, too. That is not the case, is it?

Dr. ORSZAG. Well, there are proposals that will generate \$634 billion to be devoted to health reform. The question then becomes, how are those resources used to expand benefits, coverage, and other aspects of the health care system? So there is a lot of specificity, like in slide 6, about where the \$634 billion comes from. What we are trying to work with the committee and others on is where it then goes.

Senator ENZI. All right.

I want to shift gears here. I have met with a number of people. I have been working on health IT, probably since I got here, but more specifically with Senator Kennedy over the last 4 years. We had a bill that even passed the Senate unanimously. Our focus on that bill was to get interoperability. We have improved interoperability.

I have been talking to the software manufacturers across the country, and they have been real pleased with the progress on getting the interoperability. They see that as the biggest challenge. Now, in the stimulus, we had \$19 billion. I am interested in how we are distributing that \$19 billion, but I was a little distressed because, from talking to them they said, no, if we can get the interoperability, the money will be there. How are we distributing that \$19 billion at this point?

Dr. ORSZAG. There are a variety of mechanisms. The \$19 billion actually includes both mandatory and discretionary spending. It is likely to involve significant reliance on State governments. I would note that it is not just interoperability that is a concern. I think security and privacy is also a significant concern. Actually, there are ways of doing, as you know, health information technology that not only protects privacy, but also dials it up, because with paper records I have no idea who is accessing them.

Senator ENZI. I understand that, because we just passed a bill where the security is so good—

Dr. ORSZAG. Right. I know.

Senator ENZI [continuing]. People will not be able to look at their own records, let alone have their doctor look at them.

I know my time has expired.

The CHAIRMAN. Senator Cantwell? Thank you, Senator. Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman. Dr. Orszag, good to see you. Yesterday, I think I had 1 minute to ask three questions of Ron Kirk, so the fact that I have 5 minutes to cover four topics here, I appreciate.

Dr. ORSZAG. All right.

Senator CANTWELL. But if you could help me get through those four and just give some general comments on them, I would appreciate it.

My whole framework is really about the efficiency that we see in Washington State and as we look at reforms nationally. I am trying to understand how we will be affected and what we can do in carrying some of those out. So your thoughts in general, because we have a low utilization/high outcome State.

Dr. ORSZAG. You look good on this map.

Senator CANTWELL. Yes. So what can we do to further advance the medical home and coordination in this system of reform you are talking about?

Second, your thoughts on long-term care to promote efficiency. We radically changed our system in the 1990s so that we were focusing more on home-based care. I think you say it is two-thirds more expensive to put those Medicaid patients in a nursing home than it is to focus on community-based care, so we have covered more people, kept the costs down. So I want to know what your budget reforms look like in promoting efficiency in that manner.

I just want one more reiteration on the Medicare Advantage, the low fee-for-service cost States, that you are going to make sure that those areas are protected, that we are not going to lose that opportunity. Then I will come back after you have addressed that.

Dr. ORSZAG. Sure. So in reverse order, first, on Medicare Advantage, there will be much different effects from the competitive bidding process that we have put in place across different regions than simply going 100 percent of local fee-for-service in different areas. So the whole goal of competitive bidding is to reflect the costs of private providers for providing that coverage in different areas.

With regard to long-term care: clearly a significant issue, especially for Medicaid, but not just for Medicaid, for family members, and what have you. One of the things that will need to be addressed, and I know the Finance Committee's white paper highlighted, is long-term care costs as part of overall health reform.

Then, finally, with regard to coordinated care, we had an earlier discussion, and there are still a few details to be ironed out, but one of the motivations behind bundling post-acute care and hospital payments is precisely to provide more coordinated care. One of the motivations behind the bonus-eligible organization proposal that we have is to better coordinate care. I think the evidence from the Institute of Medicine and elsewhere is that more integrated systems, where there is more care coordination, are more efficient and that should be—

Senator CANTWELL. But you would think we would see an evening out across the country then, so not the disparity between various States?

Dr. ORSZAG. One of the ways in which we could narrow the differences is through more care coordination. It is not the only way. Even in more fragmented systems, I think there are ways of moving practice norms towards more efficient outcomes. But the evidence is pretty strong that the more integrated health systems do better on the combination of lower cost and better quality than fragmented systems.

Senator CANTWELL. All right.

And if I could, on a different subject, but it is about health in general, health of our economy, I saw press reports this morning that the administration might be delaying for 5 years the procurement of a tanker air fueling system. If that is correct and you are thinking about delaying it, will you do a cost/benefit analysis on the cost of delay versus build? Because the maintenance costs of those planes are costing us a lot of money, and I think that would give us a better idea of the choices that we might face there.

Dr. ORSZAG. Let me be very clear, because I saw those press reports also: decisions about the tanker, or frankly other procurement decisions, are going to be made by the Defense Department—in this case by the Air Force and the Defense Department—and the tone of some of those press reports with regard to the role of OMB, for example, are off not only with regard to the stage of the process at which we are at, but frankly the role of OMB, period.

Senator CANTWELL. But do you think it would be wise to do a cost/benefit analysis if that was the proposal by DoD?

Dr. ORSZAG. I am going to defer to Secretary Gates in terms of the decision-making process, but presumably in deciding what to do

with the tanker and other procurement decisions, one is evaluating the costs and benefits of different approaches.

Senator CANTWELL. So that would be good to do, in general.

Dr. ORSZAG. Again, I am going to defer to Secretary Gates.

Senator CANTWELL. All right.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator, very much.

Senator SNOWE, you are next.

Senator SNOWE. Thank you, Mr. Chairman.

Welcome, Dr. Orszag. One of the initiatives that is being discussed has been the whole idea of reforming the employer-sponsored coverage through a uniform tax cap. The concerns have been raised, and I certainly raised this last week with Dr. Elmen-dorf on this question, that there are significant regional disparities in terms of providing care in States across this country, and whether or not a uniform tax could reflect those disparities in terms of higher costs in delivering health care in particular regions.

For example, in our State we have, as you have said before, low Medicaid spending, but our costs are much greater in delivering those services. There is a difference between the spending and the costs that are required in order to provide that service.

In the last administration, there was a proposal of a \$15,000 tax cap for employer-sponsored coverage. In Maine, for an individual family to purchase health insurance, it would cost \$24,000. So, it would be extremely inequitable.

What are your thoughts on that? Is there a way of indexing or phasing it out at certain income levels to reflect those disparities? Second, the equitable treatment for self-employed, for example, who are denied any tax benefits as a result of providing their own health care coverage. Is there a way of assuming cost savings, including them in providing tax benefits?

Dr. ORSZAG. I need to preface this again by saying the administration does not have a proposal in this area. It is not part of the reserve fund that we put forward. We have noted that more will be necessary. One of the ideas that other people have put on the table is the one that you mentioned, changes in the current exclusion for health insurance.

If there were changes made, there are lots of different possibilities about how it would be done. It could be done either on the individual side, or on the employer side, for example. There could be variation regionally, as you have noted, although I would point out that the tax system does not tend to differentiate, at least explicitly, in regional variation like that.

So I guess I would just come back and say, there are lots of different ways of doing it. If it were put on the table as part of health reform, there are lots of things that would need to be worked out.

Senator SNOWE. Do you acknowledge that there is a problem by providing a uniform tax cap?

Dr. ORSZAG. One of the things that happens with any uniformity in our tax code—our tax code currently has a standard deduction that does not vary by State, even though the cost of living varies by State. So we have decided as a Nation to have a uniform tax system, and there is a certain awkwardness if there are changes to the tax code to move away from that general principle. But on

the other hand, as you have noted, health care costs do vary across States, which is clearly the case.

Senator SNOWE. On another subject concerning comparative practices and their effectiveness, we, as you know, put in the stimulus plan \$1.3 billion, very limited savings. I asked Dr. Elmendorf last week why we could not have achieved greater savings by implementing this study that is part of the stimulus savings. He said that you have to employ the practices. You cannot just make assumptions about what savings might be achieved, you actually have to employ those practices.

Is there a way of establishing a process by which we do employ these practices so we can achieve greater savings using Medicaid and Medicare? I mean, obviously there must be a better way to discern how we can achieve the best standards, perhaps. And maybe they are less costly. There is no way of learning that at this point because there is no mechanism for doing so and having an independent evaluation.

Dr. ORSZAG. Let me say three things. First, and just assume that there is some medically established best practice that exists. How does that translate then into the actual practice of medicine? One is, I think the establishment of a best practice, by itself, does have some effect because doctors obviously would like to be doing the right thing.

The second is, you can create incentives for that best practice to be followed. So, for example, insurance firms can create incentives for doctors. You get a larger payment, for example, if you follow the best practice and a somewhat smaller payment if you do not, as an example.

The final thing is, there can be other changes. An example is medical malpractice. A safe harbor or defense against medical malpractice suits could be, I followed the best practice guidelines that the Institute of Medicine and the American Medical Association—or whatever body puts forward the guidelines—that I was following that.

Senator SNOWE. Well, do you think that a Center for Comparative Practices should be established as a way of doing it?

Dr. ORSZAG. There are different ways of moving forward aggressively with comparative effectiveness research. What I think is crucially important is that we do so. I know there are concerns about exactly how that center would be structured, and it is important to have medical professionals at the heart of it. But again, I think, clearly, more is necessary and there are different ways of doing it. I would hope that we could move forward on an even more aggressive approach to getting more information about what works.

Senator SNOWE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator LINCOLN?

Senator LINCOLN. Thank you, Mr. Chairman.

Dr. Orszag, we are glad you are here today as OMB Director, and certainly understand that there are many intricacies and opportunities and challenges in health care reform. We are pleased to be working with you.

I am also pleased that President Obama has recognized the dire need for health reform by including in his budget the reserve fund for health reform. We know that real reform means increasing access to affordability and access to health care, as well as bending the growth curve, and that is what we are about. We also know that health care is so intricately linked with what is going on in our economy.

A lot of my questions have been asked, and I appreciate your responses to many of those. One that I do not think has been brought up was home health. One of the areas that is slated for cuts in the budget is home health, a freeze in the market basket payment, the case mix adjustment, and the re-basing of payments, to the tune of about \$37 billion.

I have been a long-time supporter of home health care as an option for seniors. I think it is cost-effective and it is patient-preferred. It would be my understanding, and certainly witnessing, that because of home care, more patients are getting rehabilitation services, they are gaining independence, and they are staying out of more costly institutional care.

How has OMB assessed the impact of these cuts on access to home care, especially in rural areas, States like mine that are predominantly rural? We are getting estimates that 56 percent of home health agencies in my State will have a negative margin by 2010, and 73 percent have a negative margin by 2011, if the President's proposed cuts go through.

I understand the need to be fiscally responsible here and tightening our belts. We all have to do that. But is there some way that we can ensure that these changes will not adversely affect patient access or that the policy will not have the opposite of the intended effects, with higher cost to Medicare due to beneficiaries that are going to be moving to something more costly?

Dr. ORSZAG. Yes. And let me just say, again, some belt-tightening is necessary in the health system. If you look at MedPAC and other recommendations with regard to home health, while they do provide quality care, margins are also significantly higher than in other parts of the health system. For example, freestanding home health agency margins, on average, were 16 percent from 2003 to 2007, and even this year they are projected to be as high as 12 percent. I think there are lots of businesses in the United States that would love a profit margin of 12 percent this year.

So, in looking at areas where some belt-tightening is possible, we look to areas that seem to have, or sectors of the health system that seem to have, disproportionately high margins currently, and home health is one of those areas.

Senator LINCOLN. Well, CMS made a 2.75 percent across-the-board rate reduction for home health services in 2008, 2009, and 2010, and a reduction again projected for 2011. The provision was estimated to reduce outlays for home health by over \$6 billion. That reduction is based on an allegation by CMS that case mix weights have increased without attendant changes in patient characteristics that were referred to by CMS as the "case mix creep," they called it.

Dr. ORSZAG. Right.

Senator LINCOLN. Did OMB take into account what CMS learned during their comment period on the rule or the impact of that 2007 case mix adjustment?

Dr. ORSZAG. I believe the answer to that is yes. One of the reasons that the budget includes another 5.5-percent case mix adjustment for home health is evidence of that case mix creep, if you will.

Senator LINCOLN. Yes. All right. Well, I appreciate it. I would just urge us that we proceed with caution, because in terms of the long-term costs that could come from other institutionalized situations, I think home health care does provide a good quality in that.

The chronic care coordination you all have talked about a little bit. You have talked a little bit, but can you kind of discuss the leap that CBO has to make to determine the impact of avoiding the high cost of hospital readmissions, medical error, patient non-compliance, other duplicative services that are currently prevalent in our health care system? How hard is it for you to show that something has been prevented from happening, which is, I guess, what that does?

Dr. ORSZAG. Well, it is difficult, but I want to again just come back. If you look at readmission rates, for example, they are too high. Eighteen percent of Medicare beneficiaries being readmitted within 30 days, when many of those readmissions could be avoided—my view is, it makes sense to create stronger incentives for hospitals to avoid those readmissions, and also to build out the information infrastructure so that hospitals have more information about what works to avoid those readmissions in the first place.

Senator LINCOLN. Well, one of the things on chronic care coordination that we have offered up in the bill that I have been working on for several years is that we would first target the subset of Medicare beneficiaries who are likely to benefit most from coordination of care so that those who are more likely to be in that readmission or other things, because they have multiple chronic diseases that they are dealing with, that chronic care makes better sense for those folks. So, I do not know. It is something I hope we will look at in terms of cost savings.

The CHAIRMAN. Senator Kyl, you are next. Senator Kyl?

Senator LINCOLN. Thank you.

The CHAIRMAN. Thank you. Thank you, Senator.

Senator KYL. Thank you, Mr. Chairman.

Dr. Orszag, you seemed very well prepared to answer the chairman's first question about the cost of doing nothing. You have been around a long time. Can you name a member of the House or Senate who you know has advocated doing nothing in this area?

Dr. ORSZAG. No, which is why I think we are going to get health reform done this year.

Senator KYL. Thank you.

On your comment that the medical profession should not be penalized for being more efficient, I think we would all agree with that. Would it not logically follow that one of the first efforts that we should engage in to make sure that they are not penalized for being efficient is to adopt serious meaningful tort reform to preclude the medical profession from having to engage in the defensive practice of medicine?

Dr. ORSZAG. What I would come back and say, again, is many health care professionals, and doctors in particular, point to the medical malpractice system as a problem. I think there are various ways of reforming it. One of the steps that would be beneficial in having more information about what works is—the defense could be, instead of, I am doing what the guy down the hallway did, defensive medicine, I am following what, again, the Institute of Medicine or the American Medical Association, or what have you, suggested was the right way forward. So there could be a much stronger safe harbor for best practice guidelines within the medical malpractice system.

Senator KYL. Since there seems to be such a central point, I find it odd that it has not been noted in any of the presentations. I realize we do not have the full written budget of the administration, but do you think it is a significant enough factor that it ought to be included?

Dr. ORSZAG. I think it is inevitable as part of health reform, that medical malpractice will be examined. I would note that—and I used to give a “yes,” “no,” “yes” answer to this question—there are significant differences of opinion between doctors and academic researchers about the impact of medical malpractice laws, both on the variation in costs across the United States and about cost increases.

Senator KYL. Well, do you have an opinion yourself as to whether or not medical malpractice reform should be part of our solutions here to, as you say, ensure that physicians are not penalized for engaging in efficient practice?

Dr. ORSZAG. I am not allowed to have personal opinions anymore. [Laughter.]

Senator KYL. Much has been made of the comparative research funding in the budget. The concern that Senator Grassley expressed, and I am sure you have heard from others, is, of course, that the Federal coordinating council, if there should come to be such a thing, would use such information to make coverage decisions or to make reimbursement decisions.

Do you believe that it should be used for that purpose? If not, would you support creating a firewall between the work of the council and the comparative research and those kind of decisions?

Dr. ORSZAG. Let us separate two things here: one is comparative effectiveness research and the second is the kind of institute, board, or body that Senator Baucus and Senator Rockefeller and others have put forward. Comparative effectiveness itself, even within the existing system, could be used by doctors, by—

Senator KYL. It is today. Right.

Dr. ORSZAG. It is. All right. So let us leave that to the side. The second question becomes, you are deciding today what the reimbursement rate is for durable medical equipment and for wheelchairs, and for what have you. I think some of the proposals that are out there to change that decision-making does not change—the fact of the matter is, someone has to decide. The only question is, is it the Finance Committee or this other institute or board that would be making those decisions?

Senator KYL. So the answer to the question is that you believe this research would be used to make coverage determinations. The only question is by whom?

Dr. ORSZAG. No, I do not believe so. At the extreme, if something is shown not to be effective, it could simply not be covered. But there also are a lot of less extreme ways of guiding medical practice, for example, simply paying more for the things that work than the things that do not, creating penalties and what have you if you have high readmission rates, for example. So it does not need to be a simple on/off switch.

Senator KYL. No. Sure. But creating penalties for certain situations. You can make it virtually impossible for someone to use a particular method or treatment if you do not want to pay for it. Do you think that the coordinating council that has been contemplated here should be making those kinds of decisions?

Dr. ORSZAG. Again, I think, look, there are different proposals.

Senator KYL. I know it is up to us to make the decision.

Dr. ORSZAG. Right.

Senator KYL. Is that a personal opinion that you cannot hold?

Dr. ORSZAG. I would say that that is an issue that needs to be addressed as part of overall health care reform.

Senator KYL. Does the administration have a position on that?

Dr. ORSZAG. Not at this point.

Senator CARPER. Dr. Orszag, I have been at a lot of hearings before, and I have seen a lot of witnesses who have water at their table. All the times I have heard you testify as CBO Director, and here as OMB, I thought, boy, this guy is smart. I remember, we had a big Lincoln celebration in Delaware a month or so ago, celebrating his birthday, his 200th birthday.

I am reminded of a story about President Lincoln and Ulysses S. Grant, who was his top general. Some of the people who worked for Lincoln did not much like Ulysses S. Grant, and they were always calling on Lincoln to get rid of him. They called Grant an alcoholic. They said, get rid of him, he is no good. At the time, Grant was actually doing a pretty good job of leading the troops, the Union troops. Lincoln apparently said to his top advisor, "Find out what Grant is drinking and make my other generals drink it, too." [Laughter.]

We need to find out what you are drinking.

Dr. ORSZAG. I hope this is not product placement, but this is Diet Coke. Apparently there is a big controversy that has broken out between Diet Pepsi and Diet Coke and what members of the administration drink what. But this is Diet Coke.

Senator CARPER. Do you go back and forth, or are you just a straight Diet Coke drinker?

Dr. ORSZAG. No. I am a Diet Coke guy.

Senator CARPER. All right. I am glad we got that on the record.

Dr. ORSZAG. All right.

Senator CARPER. The second question. A little more serious question. When the administration was rolling out their team at OMB, one of the names that they announced was that of Nancy Killefer as Chief Performance Officer. I have huge respect for her. I thought, what a great appointment. She withdrew, for reasons that we are aware of, but I lament the fact that she is not on your team.

Have you filled that position with someone else?

Dr. ORSZAG. We have not. I am hoping that there will be an announcement or an appointment to fill that position within the next few weeks, and we have been actively interviewing and recruiting people. I am, like you, saddened by the absence of Ms. Killefer, who I think would have done a terrific job.

Senator CARPER. I would urge you as you go forward in this administration, if you have an opportunity to go back to her to ask her to find a time or willingness to serve, I would urge you to do that.

At the budget summit hosted at the White House a week or two ago, one of the issues that I raised in our breakout session dealt with improper payments. We have this improper payments law, all the Federal agencies are supposed to report improper payments. Most do, now. We know that improper payments last year were right around \$72 billion, mostly overpayments, but some underpayments. We do not do a very good job. We are doing a much better job of actually figuring out what improper payments are. We still do not do a very good job of going out and recapturing and recovering the monies that have been improperly paid or overpaid.

About 3 years ago we began doing that with respect to Medicare, and I think we did a demonstration project in three States: California, Texas, and Florida. The first year out of three of the post-recovery, we did not collect much money. The second year, we collected a little bit. Last year, I am told we collected about \$600 million. I believe there is the inclination to roll this out in the other 47 States with respect to post-audit recoveries for Medicare.

Can you confirm that for us? One of the other things that came up in our discussion, our breakout session at the budget summit, was, if we can actually recover all this money for Medicare, maybe we can do something like this for Medicaid. Can you address that?

Dr. ORSZAG. Absolutely. I think this is crucially important. This budget invests substantial resources in program integrity, that is, making sure that the right person gets the right benefit at the right time, or the right provider gets the right payment at the right time. As a result of hard evidence from pilot projects and other things, the budget projects \$50 billion in savings over 10 years from avoiding erroneous payments, not only in Medicare, but through the Social Security Administration and through the tax code. That is \$50 billion that would just go to the wrong person or provider, unwarranted, improper, and we need to be doing a much better job of protecting taxpayer dollars by investing in things that work to make sure program integrity is maximized.

Senator CARPER. All right. Good. Thanks.

Well, my other question is, expanding health insurance will only deal, I think, with one part of our health care challenge in this country. We also have to ensure that we are making every effort to keep Americans in good health as they become seriously unwell. I think the President's budget pointed out that over a third of all illness is the result of poor diet, lack of exercise, and smoking, all of which are preventable.

Can you just talk for a moment with us today about strategies currently used by Medicare and the Medicaid programs to emphasize wellness, to emphasize chronic disease management and obe-

sity reduction, and more importantly, ways that we can improve upon what is currently happening?

Dr. ORSZAG. Well, there are some efforts, but they are not where they need to be. So the budget proposes to build upon the billion-dollar prevention and wellness fund that is in the Recovery Act, yet more investment in that area because well-designed, preventative, and disease management programs can help to improve health outcomes.

Another example is, the evidence is very clear that flu vaccines for Medicare beneficiaries help not only to reduce costs, but also help them. We have strong incentives in this budget to increase flu vaccines for Medicare beneficiaries, in part because it keeps them healthier and in part because it saves Medicare dollars.

Senator CARPER. All right. Thank you, sir. Thanks very much.

Senator ENSIGN. Thank you. A couple of quick questions. One quick comment on comparative effectiveness. Others have raised the concern, if we end up with a Federal board making the decisions, even if it is made up of medical professionals, we will regret ever doing that, simply because of a bureaucracy that is set up like that that is government controlled, making changes—medicine changes so rapidly and bureaucracies do not change. They do not change rapidly enough.

To make the kind of quality updates that will need to be made, I would just caution anybody against doing that. Keep it in the private sector. Keep it in the colleges, American College of Surgeons, Cardiologists, whatever. They are the ones who actually stay the most current with the research and are the most nimble.

I have a couple of questions, though. One of the proposals out there is to have an FEHBP-type of a model, and then also have a government plan. It seems to me, and you have mentioned it before, whether we are setting the prices on durable medical equipment, at-home oxygen, whatever it is, we all acknowledge there are pricing problems. So what do we do? We look at home health. You mentioned this with Senator Lincoln. Home health. We go, all right, they are making too much money, so we can cut there. It is a very inefficient system, pricing, how much to pay a doctor for whatever. Do we not run into those problems with a government plan?

Dr. ORSZAG. Well, you run into that difficulty in any system. What I would emphasize is, I agree with you that—

Senator ENSIGN. With a government plan, the government ends up with that problem.

Dr. ORSZAG. The problem exists regardless. The question becomes—

Senator ENSIGN. The question is, who is the most efficient at doing it?

Dr. ORSZAG. And how can we move toward a system that rewards quality and not more.

Senator ENSIGN. Correct.

Dr. ORSZAG. And I think we are going to need changes to Medicare to get there, but we are also going to need changes in the private system. A lot of the private system is still based on a fee-for-service mentality also, and that needs to change.

Senator ENSIGN. Well, a lot of this happened simply because of first-dollar coverage. The first-dollar coverage was one of the biggest problems that we ever ended up with because it took a lot of the market forces out of medical decision-making. It destroyed—and that is the reason HMOs came into being. We can go through the whole history. It just seems to me that the more you take it toward a more centralized decision-making process, the more you are going to end up with problems with pricing.

I only have a very short time. What do you foresee doing? There are about 12 million people who are here in this country illegally. A lot of them do not have health insurance. They use our emergency rooms for getting their health care today.

What does the administration plan on doing with the people who are here illegally? Are you going to give them health insurance? What exactly is going to be done? Because there is no immigration policy on the table today.

Dr. ORSZAG. The President's campaign plan did not cover unauthorized immigrants. Again, I am not going to comment on the specifics of the legislation that you all are putting together, but I would imagine that there will be important protections against covering unauthorized immigrants as part of any legislation.

Senator ENSIGN. All right. And one fundamental question I keep coming up with, the \$634 billion in new cost as a down payment, we know it is going to be north of that based on your estimates. Senator Wyden and Senator Bennett had a proposal last year that the Lewin Group—they made some changes, but the score I saw from the Lewin Group is that it saved \$1.5 trillion. Now, there is a big difference between saving \$1.5 trillion and costing north of \$600 billion.

I guess I am having a little problem. Is there enough money in the health care system, and maybe it is being distributed wrong, or do we need to spend a lot more money on our health care system? There seems to be two competing arguments here: the Wyden proposal seems to save a lot of money; your proposals that you are supporting seem to cost a lot of money.

Dr. ORSZAG. Well, no. I think actually the motivation is quite similar. The Congressional Budget Office analyzed the Wyden-Bennett legislation. I happen to know the former director of CBO, so I have some familiarity with that analysis. What it found was that, once it was fully phased in, it would net to approximately zero, it would be budget-neutral. That is the goal of health reform from our perspective also. We have a reserve fund, but the overall effort should be deficit-neutral. The Wyden-Bennett proposal includes a source of revenue that is then returned to beneficiaries, but a source of revenue by changing the existing tax preferences. We have a slightly different approach for putting revenue on the table. The goal, again is—

Senator ENSIGN. It is deficit-neutral, but if that is the goal, then why would you put a \$634-billion cost in the reserve fund?

Dr. ORSZAG. The \$634 billion in savings. If all we did was the stuff that we have already put on the table, that is minus \$634 billion.

Senator ENSIGN. All right. Thank you.

The CHAIRMAN. Thank you very much, Senator.

Senator Hatch?

Senator HATCH. Well, thank you. I know you have been asked a question, but along with Henry Waxman, the author of Hatch-Waxman, that would save consumers at least \$10 billion every year since 1984, I am naturally very concerned about having a bio-similar bill or follow-on biologics bill that works.

A little over a year ago, Senators Kennedy, Enzi, Clinton, Schumer, and I agreed that we should put the bill in the HELP Committee through. Now, that bill is estimated at \$5.9 billion, if I recall it correctly, in savings, actual savings, if we put that bill through. That had 12-year data exclusivity, which is probably the most important part of the bill.

Hatch-Waxman was—the real name of it is the Drug Price Competition Patent Term Restoration Act. In other words, we had to balance the two sides. I remember the battles over that between Pharma and the generics. The generics were very upset about it, but in the end, they were about 16, 18 percent of the business at that time. Today, they are over 60 percent, and Hatch-Waxman is one of the reasons why they are.

Now, here is our problem. You have a savings, you think, of \$9.2 billion, but that is based upon data exclusivity protection of only 7 years, which will not work, when we had agreed to 12 years.

Dr. ORSZAG. Right.

Senator HATCH. Now, I have to admit, the innovative companies wanted much more than 12 years; the generic companies wanted much less than 12 years. But that is what we arrived at, and we all agreed to that. I thought with that agreement, with those very heavy stakeholders, that we could get this through. It is one of the most important bills in history because, like Hatch-Waxman, it would save trillions of dollars over the years, and it would be the innovation that we need to really bring bio-similars to the marketplace, not only in an innovative way, but also in a cost-savings way through the generics when time goes on.

So, I hope you will re-look at that, because I just do not think you can do it on a 7-year data exclusivity, and I do not know anybody who does. We will never get a bill through if that is the way the administration sticks. It would be one of the tragic things that you could do, because this bill, along with—and I was pleased with the President signing the executive order yesterday on all forms of stem cell research, but especially embryonic stem cell research. Coupled with that, we may be able to ultimately save tremendous amounts of health care costs by finding treatments and/or cures that we will never otherwise find unless the incentives are in the program.

So I hope you will take this back to the administration and to the OMB and think this through, because we arrived at those figures because we knew that is what it was going to take, to have the innovation, and yet still get that innovation ultimately to the generic companies who could bring the costs down even more—drug price competition, but also patent term restoration that gives the incentives to do the innovative work.

I just wanted to make that point with you. But let me just ask you this question. The President's budget says that the administration plans to build on the already \$1.1 billion included in the Re-

covery Act for comparative effectiveness research. Now, I agree with the value and merits of doing comparative effectiveness studies. However, in terms of looking at clinical effectiveness and either making treatment and coverage decisions because there is too much variability from patient to patient that directly affects the treatment outcomes, on page 70, the last sentence in the comparative effectiveness section states, "The findings can thereby enhance medical decision-making by patients and their physicians."

Now, I take that to mean that comparative effectiveness research will be used to solely look at clinical effectiveness and not for making treatment and coverage decisions. Based on what is written in the President's budget, is this a fair assessment? Do you agree? It is based on what you previously stated of how important it was for you and your physicians to make the treatment decisions.

Dr. ORSZAG. Well, again, I am going to come back and say I think we need much more information on what works and what does not. There are a variety of ways of using that information to affect the way medicine is practiced, and that has to be the goal.

Senator HATCH. Now, remember, that word "clinical" is very, very important not only to me, but I think anybody who looks at this, if you want to make a comparative effectiveness system work. You are key here, so I am counting on you really looking at this.

Dr. ORSZAG. Thank you, Senator.

Senator HATCH. Plus the bio-similar thing. That is very important.

The CHAIRMAN. Thank you, Senator, very much.

Dr. Orszag, I have a series of questions on long-term savings I would like to ask you. Many of us believe that, if we do health care reform right, that we can achieve significant cost savings in the years beyond the usual budget windows. Do you think that is right?

Dr. ORSZAG. Yes, sir.

The CHAIRMAN. If that is true, should we not try to recognize those savings as much as possible? Find a way to recognize the savings? Quantify them as best we can and recognize them?

Dr. ORSZAG. The best we can, recognizing that many of these things are going to be difficult to quantify precisely.

The CHAIRMAN. I did not say it would be easy, but I said we would try to recognize it.

Dr. ORSZAG. Try. Yes. The effort is worthy.

The CHAIRMAN. All right. It is "try to recognize."

Dr. ORSZAG. The effort would be a worthy one.

The CHAIRMAN. That is good. All right.

And if so, would it not be a mistake to focus unduly on paying for health care reform in the first 6 years?

Dr. ORSZAG. Well, I think there are a variety of considerations. Again, the administration has said we believe that health care reform should be deficit-neutral, even over the medium term. Then over the long term, a key is bending the curve on health care costs, which many of the things that are in your white paper will help to do.

The CHAIRMAN. But if we are going to get there, do you not think we have to pay? Do we not have to invest up front to get savings later?

Dr. ORSZAG. We do have to invest to get savings later. But again, given our medium-term fiscal trajectory, we think the best way of moving forward is to invest in a deficit-neutral way.

The CHAIRMAN. And how do you define the medium term?

Dr. ORSZAG. Five to 10 years.

The CHAIRMAN. So you want to be neutral in that period?

Dr. ORSZAG. Yes, sir.

The CHAIRMAN. And savings begin to significantly be arrived at when?

Dr. ORSZAG. That is correct.

The CHAIRMAN. When? When, savings?

Dr. ORSZAG. Savings will build over time. One of the frustrations is, there has not been enough research done on quantifying the things that we are talking about. I believe we have done everything that CBO, the Institute of Medicine, MedPAC have suggested in terms of being the most auspicious to bending the curve on health care costs over the long term: health IT, comparative effectiveness, changes in incentives, prevention, wellness, and what have you. It is very difficult to then say, in 2072 the impact on health care spending will be this.

But just as an illustration, if we could reduce the rate of health care spending growth by 1 percent a year, which may not sound like a lot, but it will be difficult to do—if we could, the power of compound interest is so strong that, after 50 years we would reduce health care spending as a share of the economy by 20 percent or so of GDP. Huge amount. One percent a year, 20 percent of GDP. That is what we need to be focusing on as we move through this effort.

The CHAIRMAN. And so, do you think that that goal of 1 percent a year can be achieved? If so, when? What would be a reasonable target date?

Dr. ORSZAG. Well, again, I was intrigued to hear that America's health insurance plans have put forward an effort to achieve exactly either 1 to 1.5 percentage-point slower growth over the next—I think Karen Ignagni said 5 to 10 years. They hope to do their part. Different parts of the system will also have to do their parts.

I think I do not want to set a specific goal, but as an illustration of the impact that different growth rates will have over the long term because of the power of compound interest, I was just trying to illustrate how big an impact—if we could achieve that, what the impact would be.

The CHAIRMAN. But is it a reasonable goal to have health care costs at no greater rate than the CPI?

Dr. ORSZAG. That would be an incredible accomplishment. I guess I would just leave it at that. I think if we could reduce—look, on average, over the past 4 decades, health care costs have been rising 2 to 2.5 percentage points faster than income per capita each year. If we could reduce that rate of so-called excess cost growth to 1, 0.5, something like that, it would still be above inflation, you would achieve significant reductions in the out-years in overall health care spending, and that would be a very good first step.

The CHAIRMAN. Right. But the question is, how do we get there? That gets to what steps we are taking to recognize those cost savings and the degree to which OMB, for example, is working to esti-

mate those cost savings, say either beyond 6 or beyond 10 years, and how you can help us identify them so that we can write legislation.

Dr. ORSZAG. Well, I would look forward to working with you, as we have over the past several years. I think your white paper includes basically those key elements of a more efficient health care system, which again have been identified as the most auspicious approaches to reducing the growth rate.

The CHAIRMAN. Right. But we just need OMB, or CMS actuaries—a lot of different outfits that have a lot more data—to help us the best we can, given the lack of data that exists.

Dr. ORSZAG. Right. And we look forward to doing that with you, yes.

The CHAIRMAN. And to sit down in the next couple of days.

Dr. ORSZAG. And again, Nancy Ann deParle will be coming up, and I know Governor Sebelius will be making visits, too, this week.

The CHAIRMAN. She is. I have appointments with both of them. That is fine. That is great. I would like to meet the wonderful ladies. I understand that. But we have to go to work. I just say, she, both the secretary and—

Dr. ORSZAG. We are all ready to roll up our sleeves, Senator.

The CHAIRMAN. Good. I know you are. That is the key right here. Thanks.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Mr. Chairman, this has been an excellent hearing, and you have summed it up in terms of having our sleeves rolled up and ready to go. I just have one additional question for Dr. Orszag. It again goes to this question of finding savings now within the current system, and it involves the role of the individual. Very often, this is called the so-called “skin in the game” kind of issue.

The way I approach this is, if you have a low-income person and they need health care, the last thing you ought to do is heap additional costs on that person. They have no money and they are not going to be able to take care of their family if you put more of a burden on them. I do think changing the private health insurance market to reward people for a careful selection of their coverage is very much in line with finding savings from the existing sums that are now being spent. I would be interested in your thinking on that.

Dr. ORSZAG. I do think that having beneficiaries pay attention—as many do, and should—to the cost of care makes sense. I would just come back, and this is something that had come up earlier. While that is helpful, we do have to remember 25 percent of beneficiaries account for 85 percent of cost. It is really the very high-cost beneficiaries who drive most of the overall cost of health care.

For them, making sure that the providers—the hospitals and their doctors—have incentives for efficient care seems to me to be key, because someone who is on the way to the hospital in the ambulance is not likely to be choosing which hospital to go to based on how much it will cost.

Senator WYDEN. There is no question that that is right. I think there is strong support for reimbursement increases in two areas. One of them is the area you have talked about, which is trying to

make sure that there is better coordination of care for those individuals, and the other is primary care.

I just know, and I am holding mine up—not to sell any private health insurance—all of us who are members of Congress, we have a choice of our coverage. So, if you make a careful selection of your coverage, you are in a position to save some money. Most Americans, even those who are lucky enough to have private health insurance coverage, do not get a choice. You have written and talked on this subject on a number of occasions, and I hope that we will see bipartisan support for that as well, because sending a message that you get rewarded for a careful selection of your private coverage makes a lot of sense.

To me, the other area, picking up on what Senator Carper talked about with prevention, is it is time to start giving financial rewards—actual financial rewards—for practicing prevention. As you know, Safeway and other companies are doing this. It seems to me that, if you lower your blood pressure and lower your cholesterol and you are on Medicare, you ought to get a lower Part B premium. How do you feel about the question of actual financial rewards for practicing prevention?

Dr. ORSZAG. They do seem to work. A variety of private firms, including the one that you mentioned, have moved forward. There are lots of ways to motivate change, and especially when it comes to health behavior. That is crucially important. So, financial incentives through insurance schemes or through bonuses for accomplishing your goals help.

I would note on a personal basis, I once had to accomplish a personal health goal and signed up on a website where a contribution would have automatically gone to a charity I did not support if I failed to meet the goal, and that worked beautifully.

Senator WYDEN. You are a poster child for my point.

Here is my last question. On Medicare Advantage, on which we are going to have obviously a spirited discussion, I come to this by way of saying that I do not think all Medicare Advantage is created equal. We have some in our part of the United States that has been very good, been very sensitive to consumer needs, and I want to be careful and make sure that those programs are not put out of business for doing good work. There are other Medicare Advantage programs, some of these private fee-for-service. Chairman Baucus has tried to reign them in, and others. But they are still out there, and a lot of that private fee-for-service is not worth a whole lot more than the paper it is written on.

Are you open to the idea of looking at the Medicare Advantage reforms almost like an insurance equivalent of pay-for-performance? If you are doing a good job and you meet a number of specific health-oriented objectives, you would not face some of these cuts, but if you are not meeting those kinds of tests, that is where you would see the budget axe fall. Are you open to that kind of idea?

Dr. ORSZAG. There are lots of ideas on the table. One of the concerns with Medicare Advantage, especially with private fee-for-service, has been inadequate attention and reporting of quality.

Senator WYDEN. Thank you, Mr. Chairman.

Senator GRASSLEY. I have just three questions, so I am not going to keep you here all day.

Dr. ORSZAG. All right, Senator.

Senator GRASSLEY. Now, the first question comes on something that you would think, why bring this up when you are talking about health care? But money is fungible, so I want to bring up something about the cap-and-trade tax.

We had Secretary Geithner here last week who told us that the cap-and-trade “does increase the cost of energy.” He also told us that “if there are additional resources beyond what we have laid out in the budget, then they will be devoted also to help compensate for those higher costs.” Moreover, there is a footnote in your budget regarding the cap-and-trade tax that says, “All additional net proceeds will be used to further compensate the public.”

So the question is, how much more revenue than the \$646 billion laid out in the budget do you expect to raise from the cap-and-trade proposal? If you cannot provide a precise estimate, please provide a ballpark figure or range. Please specify: what is the maximum amount of total revenue collected under the President’s cap-and-trade tax proposal?

Dr. ORSZAG. I do not have a specific answer for you, in part because what the President has said is that he wants to reduce carbon dioxide emissions 14 percent below 2005 levels by 2020, but there are lots of different paths or ways of getting there. How much revenue is raised will depend not only on that path, but also on details of, is it upstream or downstream, how does the system work? The President has not put forward a specific proposal that fills in those details at this point.

Senator GRASSLEY. Well, would you be able, not now but when you get back to the office, or have your staff work on something that could tell us, under various scenarios, what more might come in? I mean, we are working on a budget for the next 10 years here. If this is going to raise more—and the possibility is more because people in the administration have stressed that—we ought to have some idea what we are talking about.

Dr. ORSZAG. I think we could certainly provide an analysis of the plans that are out there and different proposals that are out there. Sure.

Senator GRASSLEY. All right. Well, please do that, then.

Second, I want to deal with disclosure and transparency of the cost of employer-sponsored health insurance. During a June 17 hearing last year before this committee, then as Director of CBO, you said, “The economic evidence is overwhelming, the theory is overwhelming, that when a company pays for a worker’s health insurance, the worker actually pays through reduced take-home pay. I don’t think workers realize that.” And then, “Making the underlying cost associated with employer-sponsored insurance more transparent might prove to be quite important in containing health care costs.”

So my question: do you still believe that disclosing the amount of health insurance coverage an employer pays on behalf of a worker could help control health insurance costs? And, two, do you believe President Obama should include a proposal to disclose the cost of employer-sponsored health insurance coverage to workers in a comprehensive health care reform package?

Dr. ORSZAG. I would say, as I said then, that I do think, when I said health care costs are reducing workers' take-home pay to a degree that is unnecessarily large and underappreciated—I believe I said that even today—the underappreciated part is, I think, because there is not as much transparency as could exist about the pass-through to take-home pay from employer-sponsored insurance.

Many firms are already moving aggressively in this direction to provide this information to workers, so one of the things that could be discussed as part of health reform is whether yet more needs to be done or whether the voluntary efforts that private firms are already taking is sufficient, because there has been a significant increase in private firms that provide that information to people already.

Senator GRASSLEY. This is something that, at least last year, and I doubt if he has changed his mind, that Senator Wyden has also been very much interested in.

Then my last question. In 2006, MedPAC stated, "The strongest incentives in the Medicare program to coordinate care are through the Medicare Advantage program. Because CMS pays Medicare Advantage plans a capitated amount for all of the enrollees' care, the plan has an incentive to ensure that beneficiaries with complex needs are well managed across the setting and over time."

Question: do you agree that a capitated payment system like the ones used in Medicare Advantage provide greater incentives for care coordination and prevention than the fee-for-service payment system?

Dr. ORSZAG. Again, I think bundling of payments does create stronger incentives. That is one reason why we moved or we proposed bundling post-acute care and hospital payments. It is another reason why we were proposing the bonus-eligible organization proposal. That bundling within Medicare helps to promote care coordination.

Senator GRASSLEY. Senator Baucus is coming back, I have just been told by staff. So, I want to ask you another question until he comes back then.

Dr. ORSZAG. Absolutely.

Senator GRASSLEY. The budget proposes a number of delivery system reforms that would require providers to collaborate in order to coordinate the care of patients. As we explore delivery system reform, are there any statutory barriers to this collaboration that we should consider addressing?

Dr. ORSZAG. I am sorry. Collaboration between who?

Senator GRASSLEY. Between health care deliverers, providers, bringing about the coordinated care of patients.

Dr. ORSZAG. There are some statutory restrictions. But I think one of the most important ways that we can move towards more coordinated care is to create incentives for doing so. Again, without repeating myself, I will just say we have a variety of proposals included in the budget intended to move in that direction.

Senator GRASSLEY. Medicare payment accuracy has long been a priority for both Senator Baucus and this Senator. In light of increasingly scarce Medicare dollars, it is even more important that these dollars are spent as accurately as possible.

The budget contains a vague proposal to use private sector mechanisms in Medicare to ensure Medicare pays accurately. In the past, Congress required that they use private sector mechanisms such as recovery audit contractors. What are these private sector enhancements that the budget proposes to ensure that Medicare pays accurately?

Dr. ORSZAG. Well, there are a variety of proposals in the budget. For example, we do propose more frequent recertification of providers under Medicare so that it is much less likely that a Medicare payment goes to an entity that is not even a Medicare provider, and also enhanced auditing capability so that even legitimate Medicare providers are not being paid for things that they do not do.

Under your leadership and others', we are trying to do that not only with regard to Medicare, but also with regard to the Social Security Administration where problems also exist, and with regard to the tax code, where the tax gap is a significant issue that needs to be reduced.

The CHAIRMAN. Thank you, Senator.

Dr. ORSZAG. Before Senator Grassley leaves——

The CHAIRMAN. Go ahead. Sure.

Dr. ORSZAG [continuing]. Can I also just say, I appreciate the fact that we held this hearing and that we are beginning the bipartisan process, and I look forward to working with you throughout. I appreciate it. Thank you.

Senator GRASSLEY. I will look forward to it in the same way.

The CHAIRMAN. Thank you, Senator.

Dr. Orszag, I would like to talk a little bit about universal coverage, individual mandates, and so forth. I believe that for us to achieve meaningful comprehensive health reform, everyone has to be covered. All Americans should be covered. There are lots of ways to approach that. Massachusetts has its approach, et cetera.

But the real question is, how do we get everybody covered? I know the President did not suggest an individual mandate during the campaign. He did suggest, however, a mandate for children, but not for all Americans.

So if we could just talk a little bit about how we get there, how we get from here to there. Without getting into what the President supports and does not support, I would just like us to have a little discussion on how we get universal coverage and get everybody in the system. What are the ways to do it? I think it is necessary to address cost-shifting that otherwise would occur if we do not. It helps us focus on prevention and wellness efforts much more effectively if everybody is covered. It is kind of a no-brainer to me that costs over time would come down if everybody was in the system. So it would help me a little bit if you could give me your thoughts on how we get universal coverage, and also, how would one implement, and execute, and enforce an individual mandate, if that were in the law?

Dr. ORSZAG. All right. Clearly, there are different ways in which one can move to expanded coverage. A key is to start bringing down the cost of coverage so that it is more affordable. That will help. In addition to that, providing health insurance in an easy and simple way. One of the reasons why employer-sponsored insurance

is so popular is that it is really easy. It is not very complicated to sign up. The employer helps you with your choice of plans, and what have you. We need to recognize that making it easy and simple is crucial.

In addition to that, you have mentioned there are different ways of encouraging further enrollment. Some people talk about heavy subsidies, others have talked about automatic enrollment with an opt-out approach, and then there is also a mandate, which is a possibility. The impact of a mandate will depend not only on how deeply subsidized the coverage is, but where and how the mandate is enforced and what the social norms are around not having health insurance.

I want to just come back for a second on the importance of coverage. In the chart pack that I gave you at the beginning, on slide 9 you see this very dramatic difference between insured beneficiaries and uninsured people in things like mammograms and colo-rectal cancer screening on the right.

The CHAIRMAN. Right.

Dr. ORSZAG. Very dramatic.

The CHAIRMAN. Right.

Dr. ORSZAG. And these have been shown. These are preventative measures that have been shown to be quite effective. Lack of insurance means people are not obtaining them at the same rate as those who are insured, and that causes problems over the medium to long term.

The CHAIRMAN. Right. So my question is, what about the people who are unemployed, who are self-employed, small group coverage? It is one thing if you work for a big company.

Dr. ORSZAG. Right.

The CHAIRMAN. That is pretty easy. Let us put that off to the side for a moment. Now we want to make sure everybody else is covered. So how do you get everybody else covered if they are not working? If they are out of the workforce, just in and out of the workforce, how do we cover them?

Dr. ORSZAG. Sure. Well, there are lots of different approaches. I know your white paper, for example, proposed that Medicaid would cover everyone under 100 percent of poverty. That is one approach. Massachusetts has another approach in which the health exchange, the Connector, provides a mechanism. The Wyden-Bennett plan has yet another kind of approach that is at least similar in spirit to that kind of exchange approach. There are lots of different ways of getting there, but it is clear we need to get there.

The CHAIRMAN. But if we had individual mandates, your thoughts on how that would be enforced. How do you enforce it?

Dr. ORSZAG. There are different approaches to enforcement. Again, not to belabor the point, but I am not saying, mandate, yes or no. We are just—

The CHAIRMAN. No. I am playing the “what if” game.

Dr. ORSZAG. The “what if” game. And I would play that to a limited degree. A “what if” game. Mandates could be enforced in different ways. There could be enforcement through the tax code, through financial penalties. The evidence does suggest that enforcement mechanisms are important. For example, if you look at the difference between the share of people who buckle their seatbelts—

very high—and the share of people who obey speeding limits—a little bit lower—I think you can see in both cases there is a set of rules, but the enforcement mechanism is different. One of the reasons is that the social norm has shifted, in a sense that, if you currently get in a car and you do not put on your seatbelt, I think the other people in the car sometimes say, what are you doing?

The CHAIRMAN. Right.

Dr. ORSZAG. And getting to that kind of point, which appears to be what happened in Massachusetts—Massachusetts has accomplished something like 97-percent coverage, even before the penalties on the mandate have kicked in. That, I think, is because not only did the system deliver effective insurance—

The CHAIRMAN. But how is the social norm conveyed?

Dr. ORSZAG. In Massachusetts, there was a huge outreach effort, a public outreach effort, to basically say, you should be insured and it is in your self-interest to be insured, and here is how you can do it. That appeared to have worked.

The CHAIRMAN. What was the nature of that outreach effort?

Dr. ORSZAG. I think you could not go anywhere in Massachusetts without reading newspaper stories or seeing advertisements for the effort under way. It was one of the biggest things that happened in Massachusetts in recent history, and so in a sense everyone knew what was happening and what was expected of individuals.

The CHAIRMAN. Is that costly? Was there a cost?

Dr. ORSZAG. In fact, there has been a lot of controversy over the costs in Massachusetts. The costs are only slightly higher than originally projected and it is almost entirely because they have succeeded much more rapidly than they thought in getting people into the system. In other words, they thought that what would happen is, coverage would rise slowly. Instead, it has basically jumped up to something like 97-percent coverage very quickly.

The CHAIRMAN. Now, intuitively we all know—in fact, your chart shows it, it is not intuitive at all, it is demonstrated—that with certain wellness and preventive measures, that over time costs are lower. How do we value wellness? How do you put a cost savings to wellness and prevention efforts?

Dr. ORSZAG. Well, this is an area where I will give you two answers. I think the more important one is, let us take off the green eyeshades. I think all of us as people value our health.

The CHAIRMAN. Right.

Dr. ORSZAG. The ultimate goal of health care, after all, is to improve people's health. So steps like prevention and better exercise programs and what have you that achieve better health just make us better off, period.

Now, with regard to—put the green eyeshades back on—cost, it has long been noted that such a large share of costs come from both very high-cost beneficiaries and from at least partially preventable diseases that, if we could figure out a way of helping people live healthier lives, there is at least the strong possibility that we could reduce costs over the long term, while also again having healthier lives, which is the ultimate objective here anyway.

The CHAIRMAN. Right. But do you target who gets the immunization shot? Do you target who gets certain wellness preventive procedures? It seems that up front there is a cost if everybody gets ev-

everything, when some are much more likely to achieve better health care than others.

Dr. ORSZAG. Well, presumably things will vary. I mean, take the flu vaccine as an example. It is actually not that expensive to administer.

The CHAIRMAN. Right.

Dr. ORSZAG. And it has been shown to reduce costs even over a very short period of time, while also improving the health of beneficiaries. That is one of the reasons why the budget includes a proposal to increase flu vaccination rates among Medicare beneficiaries. In other areas, more targeting will be necessary. I mean, for example, it does not make any sense to target an anti-smoking campaign or effort for a population that is not smoking or that is not likely to smoke, as just one example.

The CHAIRMAN. We have a very ambitious mark-up schedule here in this committee, as I have already announced, with the breaking into three subjects. We have roundtable discussions, our walk-throughs, et cetera.

Dr. ORSZAG. Yes.

The CHAIRMAN. We need some help. This is not easy. I am just curious about getting cost estimates, for example, from the Office of the Actuary at CMS. I am wondering if you could help in that regard.

Dr. ORSZAG. I would be glad to help. Again, I am ready, as I said before, to roll up my sleeves and help you accelerate this process, because we want to get it done this year.

The CHAIRMAN. I appreciate that. When you say "we," I guess we talk to everybody who seems relevant at the other end of Pennsylvania Avenue. But I am thinking about HHS Secretary-to-be Sebelius, and Nancy-Ann deParle, and yourself. Whom would we talk to? How do we coordinate this?

Dr. ORSZAG. I think, from the White House, Nancy-Ann will be up this week to meet with you, and she should be the direct point of contact. Obviously it would be beneficial to have the nominee for Secretary of HHS confirmed as soon as possible so that she can play a role.

This is such a huge undertaking that a collaborative teamwork approach is going to be necessary, so I think you are going to be seeing many of us from the administration actively involved, as should be the case given the magnitude of what we are trying to accomplish.

The CHAIRMAN. Is there anything off the table as far as the administration is concerned?

Dr. ORSZAG. Not to my knowledge, no. Everything is on the table.

The CHAIRMAN. All right. This is a great, big table, and it is stacked pretty high.

Director Orszag, thank you so much. I deeply appreciate your enthusiasm, your dedication, and your intelligence. It is going to be needed and utilized when we get across the finish line.

Thank you very much.

Dr. ORSZAG. Thank you, sir.

[Whereupon, at 12:35 p.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Testimony of Peter R. Orszag

Chairman Baucus and Ranking Member Grassley, thank you not only for your extraordinary leadership on health care reform, but also for your participation and contributions during the White House Forum on Health Reform. I look forward to continuing to work with you, other members of this Committee, and other policymakers to get health reform enacted this year.

I come before the Committee at a time of great peril for our economy and for our nation's fiscal future. The Administration has inherited an economic crisis unlike any we have seen in our lifetimes. Our economy is in a deep recession, which threatens to be more severe than any since the Great Depression.

The result of this bleak economic picture, as well as the misplaced policy priorities of previous years, is a pair of twin deficits, each in the range of \$1 trillion per year. The first trillion dollar deficit is the gap between how much the economy has the potential to produce and how much it is actually producing each year. This output gap of roughly \$1 trillion in 2009 would represent nearly 7 percent of the estimated potential output of the economy. The Recovery Act that Congress passed a few weeks ago was a bold and important first step toward filling this hole and jumpstarting the economy through fiscal stimulus that increases short-term demand for goods and services.

The second trillion dollar deficit that the new Administration is inheriting is the budget deficit. Under current policies, we face fiscal deficits of almost \$1 trillion a year on average over the coming decade. OMB projects that the baseline deficit for FY 2009 will be about \$1.5 trillion, or 10.6 percent of GDP. Over the ten-year budget window, from FY 2010 to FY 2019, aggregate baseline budget deficits will total nearly \$9.0 trillion and average almost 5 percent of GDP. Over longer periods of time, the deficit reaches even higher shares of GDP primarily because of rising health care costs.

Over the medium to long term, the nation is thus on an unsustainable fiscal course. We need to act, and since the key to our fiscal future is health care, it makes sense to begin the process of putting the nation on a sounder fiscal path by tackling health reform. I will spend the remainder of my time today focusing primarily on proposals in the President's Budget for dealing with rising health care costs and the need to provide all Americans with affordable, high-quality health care, along with a few other key health care investments in the Budget.

Containment of Health Care Costs

Controlling health care cost growth is the key to our long-term fiscal future. Total national health spending has increased from about six percent of GDP in 1965 to more than 16 percent in 2007. This rise in health care as a share of the economy is expected to

continue in the future; between 2008 and 2018, average annual health spending growth is anticipated to outpace average annual growth in the overall economy by 2.1 percentage points per year. As a result, by 2018, national health spending is expected to account for just over one-fifth (20.3 percent) of GDP.^[1]

These projected increases in overall health costs drive the cost trends in our public insurance programs – which are themselves the primary driver of our long-term fiscal gap. For example, if costs per enrollee in Medicare and Medicaid grow at the same rate over the next four decades as they did over the past four decades, those two programs will increase from about five percent of GDP today to about 20 percent by 2050.^[2] As the Centers for Medicare and Medicaid Services (CMS) actuaries, the Congressional Budget Office (CBO), and others have noted, there are reasons to expect cost growth to slow in the future relative to the past even in the absence of policy changes.^[3] But the point remains that reasonable projections of health care cost growth under current policies shows that they are the principal driver of the nation’s long-term fiscal imbalance.

The large projected increases in cost in Medicare and Medicaid, in turn, are mostly a reflection of rising costs per beneficiary, not the effects of demographics. In other words, costs increase mostly because each beneficiary is expected to cost significantly more in the future than today – and only partially because we will have more (and older) beneficiaries in the future.

These observations lead to an emphasis on reducing costs per beneficiary over time – not only in Medicare and Medicaid, but also in the overall health care system. The effects of rising health care costs are not limited to public programs. Health care cost growth can impede the growth of cash earnings for workers with employer-based coverage. While employers may appear to cover much of the cost of health insurance for employees, economists generally agree that workers ultimately bear most of those costs through wages and other forms of compensation that are lower than they otherwise would be. Also, as the costs of medical care increase, employers may find it difficult to offset their health insurance costs through reduced wages, and may instead reduce benefits or increase the costs (e.g., deductibles, premiums) paid directly by workers, which would result in more workers forgoing employer-based health insurance. Rising health care costs also make individual private coverage prohibitively expensive for more individuals. As health costs and premiums rise, so too does the number of uninsured Americans.

Substantial opportunities appear to exist to reduce health care costs without impairing quality of care or outcomes. In particular, evidence suggests that a significant share of

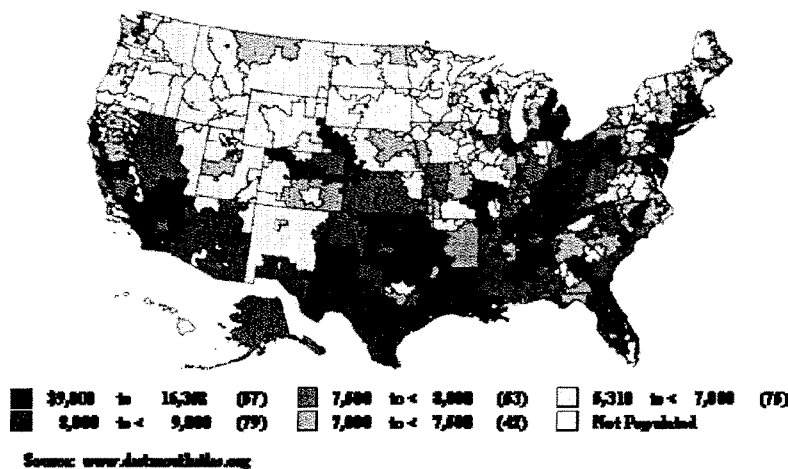
^[1] CMS. National Health Expenditures Data. http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage

^[2] Letter from CBO Director Orszag to Senator Judd Gregg. “Financing Projected Spending in the Long Run.” July 9, 2007.

^[3] CMS Office of the Actuary. Memo on “The Long-Term Projection Assumptions for Medicare and Aggregate National Health Expenditures.” March 25, 2008.

current health care spending contributes little if anything to the overall health of the nation. Perhaps the most compelling evidence of this opportunity is that spending varies substantially across the United States, mostly because of variation in the volume and intensity of services provided. The Dartmouth Atlas project found that Medicare spending in 2006 varied more than threefold across U.S. hospital referral regions.^[4] However, Medicare enrollees in areas with higher spending do not appear to have better health outcomes on average than those in areas with lower spending.

Medicare Spending Per Capita by Hospital Referral Region, 2006



Variations in spending appear to be driven in large part by different professional norms across our nation – and the higher-cost norms in some parts of the country are not more effective (and may be less effective) than the lower-cost norms in other parts of the country. Research indicates that discretionary decisions by physicians regarding referrals to specialists, diagnostic tests, and hospital admissions contribute to higher costs.^[5] Differences in supply are also important; supply appears to generate its own demand.^[6] Some researchers believe health care costs could be reduced by a stunning 30 percent—

^[4] Dartmouth Institute for Health Policy and Clinical Practice. “Health Care Spending, Quality, and Outcomes, More Isn’t Always Better. February 27, 2009.

^[5] Dartmouth Institute for Health Policy and Clinical Practice. “The Policy Implications of Variations in Medicare Spending Growth.” February 27, 2009.

^[6] Dartmouth Institute for Health Policy and Clinical Practice. “Health Care Spending, Quality, and Outcomes, More Isn’t Always Better. February 27, 2009.

or about \$700 billion a year—without harming quality if we moved as a nation toward the proven and successful practices adopted by lower-cost areas and hospitals.^[7]

Slowing Health Spending Growth While Expanding Coverage

Moving toward a more efficient and high-quality health care system would make better use of existing Federal spending and help to expand health insurance coverage. Our current system of providing health care for the uninsured is composed of a patchwork of government subsidies, safety net programs, and charity care from many sources. Such a system has serious gaps; in most States there are few to no affordable options for poor adults without children. It is also poorly designed to provide quality and cost-effective care. Research has found that the uninsured are less likely than the insured to have regular outpatient care and are more likely to be hospitalized for avoidable health problems.^[8] The uninsured are also less likely to receive preventive care that may help avoid more serious and costly illnesses.

Health care for the uninsured is currently funded directly or indirectly through a variety of sources, including the government and private insurers. One study estimated that individuals who were uninsured for any part of 2008 spent about \$30 billion out of pocket and received approximately \$56 billion in uncompensated care while uninsured, and that government programs finance about 75 percent of uncompensated care.^[9] Examples of Federal sources of funding that help subsidize uncompensated care include roughly \$20 billion in estimated disproportionate share hospital (DSH) payments made through Medicare and Medicaid in 2009. The Federal government also provides funds to support community health centers and other programs that provide health care for the uninsured. Recent estimates indicate that hospitals provided about \$35 billion in uncompensated care in 2008, and that perhaps as much as half of those costs were shifted to private insurers, which would then raise premiums for the insured.^[10] Both this hidden tax and Federal spending through various programs could be reduced if health care reform that covered all Americans were enacted.

The Administration believes that it would be irresponsible to expand coverage without accompanying changes to reduce health costs, and that it would be short-sighted to reduce costs without expanding coverage to Americans who need it. The savings from reducing health care cost growth compound over time and the power of compound interest is so strong that such savings will ultimately more than offset the costs of providing essential health insurance to more Americans. As the President said at the White House Forum on Health Reform, he developed a strong plan during the campaign that would make up-front investments to expand coverage and reduce costs. He also

^[7] CBO Testimony. Increasing the Value of Federal Spending on Health Care. Before the House Committee on the Budget. July 16, 2008. <http://www.cbo.gov/ftpdocs/95xx/doc9563/07-16-HealthReform.1.2.shtml>

^[8] Kaiser Family Foundation. The Uninsured, A Primer. Key Facts about Americans Without Health Insurance. October 2008.

^[9] Hadley, Jack; John Holahan; Teresa Coughlin, and Dawn Miller. Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs. Health Affairs. Web Exclusive. 2008.

^[10] Ibid. Also, CBO. "Key Issues in Analyzing Major Health Insurance Proposals. December 2008.

underscored that he has no monopoly on good ideas and will consider all serious ideas that, in a fiscally responsible manner, ensure quality, affordable coverage for all Americans.

Administration Actions

The Administration is moving aggressively to reduce costs, improve quality, and expand coverage. The key steps to reduce costs over time and “bend the curve” involve:

- Investing in information technology, a step that is necessary for a high-performing health care system;
- Conducting comparative effectiveness research, to examine what works and what doesn’t so doctors have better information on appropriate treatments;
- Modernizing public program payment systems, so that we reward better care rather than simply paying for more care; and
- Promoting prevention and wellness, so that Americans are healthier.

In addition to expanding coverage, the Administration is moving aggressively on all four of these steps to improve the efficiency of the health system.

Reauthorization of the Children’s Health Insurance Program (CHIP)

In one of his first official acts, the President signed into law the reauthorization of CHIP, extending the program through 2013 and providing coverage to the seven million children it currently insured and an additional four million uninsured children on average. This bill was a first step toward fulfilling the Administration’s goal of providing health insurance coverage for all Americans. The President is committed to implementing this Act as quickly as possible to help children in families affected by this economic downturn. The CHIP legislation was one component of the Administration’s efforts to modernize health care in America, and was shortly followed by the American Recovery and Reinvestment Act of 2009.

The American Recovery and Reinvestment Act of 2009

The Recovery Act makes important investments in reinforcing Federal assistance to States through the Medicaid program; continuing health care coverage and services for low-income individuals; computerizing America’s health records; developing and disseminating information on the most effective medical interventions; and prevention and wellness interventions.

- Reinforce Federal Assistance to States. The Recovery Act provides States with a temporary increase in the Federal medical assistance percentage (FMAP), the Federal share of spending in the Medicaid program. This assistance is provided via three pillars of support: (1) temporary suspension of FMAP decreases via a hold-harmless provision; (2) a general 6.2 percentage point increase in the Federal share of Medicaid; and (3) a sliding-scale decrease in the State Medicaid share for

those States that experience high increases in their unemployment rates. The Act requires maintenance of effort for eligibility and requires compliance with statutory prompt pay requirements, including to nursing facilities and hospitals.

- Extend COBRA Coverage. The Recovery Act provides a 65 percent reduction in COBRA premiums for certain assistance eligible individuals to help make health care affordable. This provision will help seven million Americans keep their health care.
- Continue Health Care Supports for Low-Income Individuals. The Recovery Act extends both Transitional Medical Assistance (TMA) and the Qualified Individuals (QI) program through December 31, 2010. TMA provides access to Medicaid coverage for low income families with children who are transitioning into the workforce, and the QI program provides Medicare Part B premium assistance for eligible low-income beneficiaries.
- Computerize America's Health Records in Five Years. The current, paper-based medical records system that relies on patients' memory and reporting of their medical history is prone to error, time-consuming, costly, and wasteful. At present, perhaps only 17 percent of U.S. physicians and 8 to 11 percent of U.S. hospitals have at least a basic electronic record system. Far fewer have and routinely use the types of comprehensive systems that would allow them to fully realize the potential of the technology. With rigorous privacy standards in place to protect sensitive medical records, we are embarking on an effort to computerize America's health records in five years. This effort will help prevent medical errors and improve health care quality, and is a necessary step in starting to modernize the American health care system and reduce unnecessary health care costs.
- Develop and Disseminate Information on the Relative Effectiveness of Medical Interventions. Medicine is changing so rapidly that it is almost impossible for any individual physician to keep abreast of all the latest research studies. Each month nearly 500 articles are published on breast cancer alone. Despite this profusion of research, there are often gaps, especially in studies that compare how well different diagnostic tests and treatments work for the very same conditions and diseases. Without the most recent information on the effectiveness of alternative treatments, it is difficult for doctors to give each patient the type of treatment he or she deserves. To help patients and providers get the information they need for the highest quality care, the Recovery Act devotes \$1.1 billion to comparative effectiveness research—studies on the relative advantages and disadvantages of competing medical interventions. The information from this research should help improve the performance of the U.S. health care system.
- Invest in Prevention and Wellness. Over a third of all illness is the result of poor diet, lack of exercise, and smoking. Indeed, obesity alone leads to many expensive, chronic conditions including high blood pressure, heart disease,

diabetes, even cancer. Furthermore, there are important vaccines that can prevent disease and screening tests that can detect cancer and other diseases at an early stage when they are more curable. Yet many Americans are not getting these effective treatments. For instance, according to the CDC, fewer than 75 percent of women recommended to do so get mammograms and fewer than 50 percent of Americans recommended to do so receive any type of colon cancer screening. The Recovery Act devotes an unprecedented \$1 billion for prevention and wellness interventions. This will dramatically expand funding for immunizations, healthcare acquired infections, and community-based interventions proven to reduce chronic diseases.

- Strengthen the Health Workforce. The President believes that a strong health workforce, including doctors, nurses, community health workers and public health practitioners, are the lynchpin to an effective health care system. The law provides \$500 million to support programs like the National Health Services Corps, which place providers in underserved communities. Further, it will fund existing workforce programs (Title VII and VIII) which are critical for the education and training of the next generation of doctors and nurses.

Health Care Reserve Fund

As the President said at the White House Forum on Health Reform this past Thursday, health care reform is no longer just a moral imperative, it is a fiscal imperative. The President's Budget sets aside a reserve fund of more than \$630 billion over ten years dedicated to financing reforms to the American health care system that will lower costs, put us on a clear path to cover all Americans and improve quality. The reserve fund is financed roughly 50-50 between a combination of re-balancing the tax code so that the wealthiest pay more and specific health care savings in three areas: promoting efficiency and accountability, aligning incentives toward quality, and encouraging shared responsibility.

The Budget includes a proposal to limit the tax rate at which high-income taxpayers can take itemized deductions to 28 percent. This policy limits, but does not eliminate, the tax break for families with income above \$250,000. The initial reserve fund would be about half funded through this progressive provision, which would raise \$318 billion over ten years. In the health reform policy discussions that have taken place over the past few years, a wide range of other revenue options have been discussed—and these options are all worthy of serious discussion as the Administration works with Congress to enact health care reform.

On the savings side, the Budget proposes improvements to Medicare and Medicaid, which are discussed in detail later in my testimony and would achieve \$316 billion in savings over ten years. These proposals would simultaneously help to improve the quality and efficiency of health care without negatively affecting the care Americans receive.

Although the reserve fund represents a major commitment to reform, the Administration recognizes that the reserve is not sufficient to fully fund comprehensive reform, and we are committed to working with Congress to find additional resources to devote to health care reform. By identifying specific health savings for the health care reserve fund, the Administration is making a down payment on two goals: expanding health care coverage to all Americans and restraining growth in health care costs. Progress on these goals will be a continuous effort of the Administration. As additional information from research, demonstration projects, and other sources becomes available, it will be used to develop new and refined means of addressing these challenges.

Approach to Health Care Reform

The President is eager to work with Members of Congress to develop a comprehensive health care reform proposal that will provide high-quality, affordable health coverage to all Americans while addressing long-term drivers of health spending in public and private health programs. Many promising approaches to health reform have been proposed by many different people, and the President looks forward to developing a health reform approach through an open and inclusive process that explores all serious ideas that achieve the common goals of expanding coverage, improving quality, and constraining costs. To get a sense of what elements the Administration believes are key pieces to include in any health reform proposal, I want to summarize the Administration's eight guiding principles for health reform.

1. **Protect Families' Financial Health.** The plan must reduce the growing premiums and other costs American citizens and businesses pay for health care. People must be protected from bankruptcy due to catastrophic illness.
2. **Assure Affordable, Quality Health Coverage for All Americans.** The plan must put the United States on a clear path to cover all Americans. The plan must reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added health benefits.
3. **Provide Portability of Coverage.** People should not be locked into their job just to secure health coverage.
4. **Guarantee Choice of Doctors.** The plan should provide Americans a choice of health plans and physicians. Also, they should have the option of keeping their employer-based health plan.
5. **Invest in Prevention and Wellness.** The plan must invest in public health measures proven to reduce cost drivers in our system—such as obesity, sedentary lifestyles, and smoking—as well as guarantee access to proven preventive treatments.
6. **Improve Patient Safety and Quality Care.** The plan must ensure the implementation of proven patient safety measures and provide incentives for

changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered.

7. **End Barriers to Coverage for People with Pre-existing Medical Conditions.** No American should be denied coverage because of preexisting conditions.
8. **Reduce Long-term Growth of Health Costs for Businesses and Government.** The plan must pay for itself by reducing the level of cost growth, improving productivity, and dedicating additional sources of revenue.

The Administration looks forward to working with Members of Congress to develop a detailed health reform proposal through an open and inclusive process.

Strengthening Medicare

Without a change in policy, Federal Medicare spending is expected to more than double between 2009 and 2019 from approximately \$425 billion in 2009 to \$872 billion in 2019. The Hospital Insurance (HI) trust fund is expected to be exhausted within the next ten years.

The Budget would improve the Medicare program for beneficiaries by aligning incentives toward quality, promoting efficiency and accountability, and encouraging shared responsibility. These proposals would also strengthen the program's finances, extend solvency of the HI trust fund by two years, and reduce average annual growth in spending from 7.4 percent to 6.8 percent over the next ten years.

The Budget includes the following proposals:

- Reduce Medicare overpayments to private insurers through competitive payments. Under current law, Medicare pays Medicare Advantage plans 14 percent more on average than what Medicare spends for beneficiaries enrolled in the traditional fee-for-service program. This is because the current system bases payments on administratively determined benchmarks that are set well above the cost of providing fee-for-service Medicare benefits. Let me illustrate how inefficient this is. MedPAC estimates that the Federal government pays \$1.30 for each \$1.00 in Medicare Advantage supplementary benefits, without any compelling evidence of better quality of care. Medicare Advantage overpayments undermine Medicare's financial future and are estimated to increase premium costs this year for beneficiaries in Medicare fee-for-service by approximately \$3 per person per month.

The Administration would replace the current mechanism used to establish payments with a new competitive system in which payments would be based upon an average of plans' bids submitted to Medicare. The Administration's proposal

would better align plan payments with the actual cost of coverage. This would allow the market, not Medicare, to set the reimbursement limits. Our proposal would save taxpayers more than \$175 billion over ten years as well as reduce Part B premiums.

- Reduce drug prices. The Administration will accelerate access to affordable generic biologic drugs through the establishment of a workable regulatory, scientific, and legal pathway for generic versions of biologic drugs. To retain incentives for the research and development of breakthrough products, a period of exclusivity would be guaranteed for the original innovator product, which is generally consistent with the principles in the Hatch-Waxman law for traditional products. Brand biologic manufacturers would also be prohibited from reformulating existing products into new products to restart the exclusivity process, a process known as ever-greening. Furthermore, the Administration would prevent drug companies from blocking generic drugs from consumers by prohibiting anticompetitive agreements and collusion between brand name and generic drug manufacturers intended to keep generic drugs off the market.

The Budget would also bring down the drug costs of Medicaid by increasing the Medicaid drug rebate for brand-name drugs from 15.1 percent to 22.1 percent of the Average Manufacturer Price, applying the additional rebate to new drug formulations, and allowing States to collect rebates on drugs provided through Medicaid managed care organizations.

- Improve Medicare and Medicaid payment accuracy. The Government Accountability Office (GAO) has labeled Medicare “high-risk” due to the billions of dollars lost to overpayments and fraud each year. The Administration proposes \$311 million in FY 2010 for program integrity activities for CMS that will initially be targeted to remedy the vulnerabilities in Medicare, including Medicare Advantage and the prescription drug benefit (Part D), as well as Medicaid. CMS will be able to respond more rapidly to emerging program integrity vulnerabilities across these programs through an increased capacity to identify excessive payments and new processes for identifying and correcting problems. With this additional funding, the Administration will be better able to minimize inappropriate payments, close loopholes, and provide better value for program expenditures to beneficiaries and taxpayers.
- Improve care after hospitalizations and reduce hospital readmission rates. Nearly 18 percent of hospitalizations of Medicare beneficiaries result in the readmission of patients who have been discharged from the hospital within the last 30 days. Sometimes such readmissions cannot be prevented, but many are avoidable. Under the policy in the Budget, hospitals would receive bundled payments that cover not just hospitalization, but care from certain post-acute providers for the 30 days after hospitalization, and hospitals with high rates of readmission would be paid less if certain patients are re-admitted to the hospital within that 30-day period. This combination of incentives and penalties should lead to better care

after a hospital stay and result in fewer readmissions—saving roughly \$26 billion over ten years.

- **Expand the Hospital Quality Improvement Program.** The health care system tends to pay for the quantity of services delivered, not their quality. Experts have recommended that hospitals and doctors be paid based on delivering high quality care, or what is called “pay for performance.” The Budget proposes to link a portion of Medicare payments for acute inpatient hospital services to hospitals’ performance on specific quality measures. This program would improve the quality of care delivered to Medicare beneficiaries and is estimated to save more than \$12 billion over ten years.

No single proposal or approach will address all the factors that contribute to growing health care costs. Rather the Administration will engage in continuous efforts that will lead progressively over time to more efficient and high-quality health care. The President welcomes the opportunity to work with Members of Congress to strengthen the Medicare program. Both Medicare and Medicaid policy changes could complement broader efforts to contain cost growth in the rest of the nation’s health care system. The Administration will consider and evaluate additional options to strengthen Medicare, guided by the following four principles.

Build the Base of Information to Undertake Future Program Modernization. First, we must pursue a vigorous research and demonstration agenda in order to lay the foundation for future improvements in our payment systems. The Budget includes new funding to do just that. New Medicare and Medicaid demonstration and pilot projects will advance the Administration’s objectives for improving the Medicare and Medicaid programs by evaluating payment reforms, options to provide higher quality care at lower costs, and to improve beneficiary education and understanding of benefits offered.

Pursue Options to Address the Underlying Causes of Unnecessary Health Care Spending. While many analysts agree that more information is needed about which treatments work best for a given patient, the effect of information alone generally would be limited. In many cases, the current system does not create incentives for doctors, hospitals, other providers, or patients to avoid costs that do not substantially improve healthcare outcomes. We need stronger payment incentives to adopt evidence-based standards of care and to encourage use of high-value care. Also, most analysts attribute the bulk of cost growth to the development of new treatments and other medical technologies.^[11] Medicare payment systems tend to encourage the adoption of newer, more-costly services even in the absence of clear evidence establishing that those services are better. Therefore, we also need to think about payment policies that reward use of efficient and effective medical technologies.

Encourage Care Coordination, Prevention, and Other Services That Promote High Quality, Efficient Health Care. Health care in the United States is characterized by high spending without commensurately better health outcomes, relative to other industrialized

^[11] CBO. Technological Change and the Growth of Health Care Spending. January 2008.

nations.^[12] Our fragmented health care delivery system, which lacks care coordination and rewards intensive and high-cost care over preventive care, contributes to this result. For instance, more than two-thirds of Medicare spending is for beneficiaries with five or more chronic conditions.^[13] Medicare patients with chronic diseases (e.g., diabetes, congestive heart failure, renal failure) may receive care from multiple physicians and providers at the same time and take a number of different drugs to treat their various conditions. However, patients and families often must manage their own care unassisted across different providers. The lack of clear accountability among multiple providers for managing care, communicating with patients and each other regarding a plan of care, and for a patient's health outcomes leads to medical errors, duplication of services, and unnecessary spending.

Most of Medicare's current payment systems reinforce fragmentation by paying each provider separately and by paying for greater volume and intensity of services even when a more efficient mix of services could produce similar or superior health outcomes. Moreover, the current payment structure offers little incentive for physicians, hospitals, and other providers to integrate, coordinate care, improve the quality of care, or to control the cost of care across the spectrum of settings. Their lack of coordination among physicians, hospitals, and other providers is exacerbated by inadequate adoption and use of electronic health records, which further impedes the coordination of medications, tests, and referrals. The Recovery Act takes essential first steps in building the infrastructure for modernizing the health care system, for example by providing Medicare incentive payments for physicians and hospitals that are meaningful users of electronic health records and through investments in research on the most effective medical treatments. However, we need to build upon this infrastructure to create new financial incentives across Medicare payment systems to promote integration, quality, and high-value care for beneficiaries and taxpayers.

There are several approaches to encouraging greater coordination of care, and as I mentioned previously, the Budget's proposals would begin this transformation. For example, the Budget includes proposals to bundle payments for a hospital stay and post-acute care providers and to reduce payments to hospitals in certain cases when patients are readmitted within 30 days. CMS is conducting a demonstration project that tests the use of a bundled payment for both hospital and physician services for a select set of inpatient episodes of care. By moving away from a fragmented fee-for-service system and toward bundled and more integrated payment systems that include a broad array of

^[12] The United States spent 15.3 percent of GDP on health care, more than any other Organization for Economic Cooperation and Development (OECD) country in 2006 and well above the OECD average of 8.9 percent. The United States also has the highest health expenditure per capita spending of any OECD country, at \$6,714 in 2006, compared with the OECD average of \$2,824. The United States had below average life expectancy in 2005 and the highest obesity rate for adults in 2006 among OECD countries for which measures were available. "OECD Health Data 2008: How Does the United States Compare." <http://www.oecd.org/dataoecd/46/2/38980580.pdf>. OECD Data 2008—Frequently Requested Data. http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html (downloaded November 30, 2008).

^[13] Partnership for Solutions. "Chronic Conditions: Making the Case for Ongoing Care. September 2004 Update. Johns Hopkins University and Robert Wood Johnson Foundation. Slide 27.

services and providers, we would create financial incentives for physicians and providers to coordinate care, improve the quality of that care, and provide care in the most efficient and clinically-appropriate setting.

We can also encourage greater coordination and quality of care by making specific payments to providers for the care coordination role and linking a portion of payments to performance on quality measures. The Budget includes a proposal that would enable physicians to form voluntary groups that coordinate care for Medicare beneficiaries and to receive performance-based payments for the coordinated care. The Budget also includes, as I previously discussed, a proposal to create hospital quality incentive payments in which a portion of payments is directly tied to hospitals' performance on certain measures. CMS is also conducting demonstration projects that test the effect of quality incentive payments on home health agencies and skilled nursing facilities.

Other approaches include medical homes, disease management organizations, and community networks or teams to coordinate care, improve patient compliance with plans of care, and encourage preventive health care and patient wellness. The Department of Health and Human Services is beginning to test these concepts and examine the research, and will make recommendations that the Administration will consider in developing future options for modernizing Medicare's payment systems.

As part of the ongoing effort to encourage care coordination, appropriate use of preventive services, and high-quality health care, Medicare payment policies need to forge closer ties between payments and individual physician performance and efficiency.

The Administration believes that the current physician payment system, while it has served to limit spending to a degree, needs to be reformed to give physicians incentives to improve quality and efficiency. Thus, while the baseline reflects our best estimate of what the Congress has done in recent years, we are not suggesting that should be the future policy. As part of health care reform, the Administration would support comprehensive but fiscally responsible reforms to the payment formula. The Administration believes Medicare and the country need to move toward a system in which doctors face better incentives for high-quality care rather than simply more care.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires a report on value-based purchasing for physicians, which can help inform policy decisions. There are also a number of demonstration projects and policy options that could help Congress and the Administration consider how best to encourage more efficient and high-quality medical practice patterns. CMS is conducting several demonstration projects that offer incentive payments for physicians to provide preventive services and coordinate care to help patients avoid more costly illnesses. The Administration wants to examine a wide variety of options and engage in an open process to improve quality and efficiency in physician services. Lastly, one factor that helps perpetuate inefficiencies in health care is a lack of clarity regarding what it costs and who bears those costs. Beneficiaries' responsibility for costs may vary depending on the type of service, the part of Medicare that covers it, and whether they have supplemental coverage. It may also vary based on

their income level, in the case of Part B premiums. Policies to improve beneficiaries' ability to be partners in improving the value of care also will be explored.

Improve Medicaid and Children's Health Insurance Program (CHIP) Coverage for Low-Income Individuals

The Recovery Act protects health care coverage for millions of Americans during the recession by temporarily increasing Federal funding to help States facing budget shortfalls maintain their current Medicaid and CHIP programs. While the Recovery Act provides more funding to support Medicaid, the Budget proposes to make sure these funds are spent efficiently by focusing on proposals to improve Medicaid financing and program integrity, reducing costs and helping States detect and avoid improper payments.

- Contain drug spending. Prescription drug costs are high and rising. The Budget would bring down the drug costs of Medicaid by increasing the basic drug rebate for brand-name drugs from 15.1 percent to 22.1 percent of the Average Manufacturer Price, allow States to collect rebates on drugs provided through Medicaid managed care organizations, and apply the additional drug rebate to new formulations of existing drugs. All the savings would be devoted to the health care reserve fund. The Budget also establishes a pathway for affordable generic versions of biologic drugs. To retain incentives for research and development for the innovation of breakthrough products, a period of exclusivity would be guaranteed for the original innovator product, consistent with Hatch-Waxman principles for traditional products.
- Improve payment accuracy. The Budget directs CMS to remedy vulnerabilities in Medicare and Medicaid. CMS will be able to respond more rapidly to emerging program integrity vulnerabilities across these programs through an increased capacity to identify excessive payments and new processes for identifying and correcting problems.

Additional Health Investments

The FY 2010 Budget includes \$76.8 billion in discretionary funding for HHS. We will transmit a more detailed Budget in April, but three key initiatives that I would like to highlight are:

- Food and Drug Administration (FDA). The Budget includes more than \$1 billion to strengthen FDA's efforts to make food safer. It also supports FDA's new efforts to allow Americans to buy safe and effective drugs from other countries and to establish a new regulatory pathway to approve generic biologics.
- National Institutes of Health (NIH) – Cancer. Over \$6 billion is included in NIH to begin a multi-year plan to double cancer research. These resources will be committed strategically, to have the greatest impact on developing innovative diagnostics, treatments, and cures for cancer. This initiative will build upon the

unprecedented \$10 billion provided in the Recovery Act for various types of activities, including cancer and other disease research, in 2009 and 2010.

- Indian Health Service (IHS). The Budget includes over \$4 billion for the Indian Health Service to support and expand the provision of health care services and public health programs for American Indians and Alaska Natives. Investments will focus on improving the health outcomes to address persistent health disparities and foster healthy Indian communities.

Strengthen and Target Family Support Programs

In addition to the Medicare, Medicaid and CHIP initiatives described above, the Budget also invests resources in rigorously evaluated and effective family support programs to improve child health and life outcomes. For example, the Budget builds the framework for creating and scaling up a Nurse-Home Visitation program that could ultimately serve all eligible first-time mothers who seek services. Rigorous research has shown, with rare consistency, that a well-implemented nurse home visitation program can have large and sustained impacts on important outcomes for children and families. This program saves money in the long-term by reducing child abuse and neglect, preterm births, and arrest rates for both parents and adolescents who participated in the program.

Also, the Recovery Act makes historic investments in early childhood programs including Head Start and Early Head Start, and the 2010 Budget sustains those levels.

The Recovery Act includes an additional \$1 billion for Head Start, \$1.1 billion for Early Head Start expansion, and \$2 billion for the Child Care and Development Block Grant (CCDBG). This level will double the number of children served by Early Head Start and expand and improve Head Start. The increase in CCDBG will make child care assistance available to more low-income working families and provide additional funds for States to improve the quality and availability of child care services. The Recovery Act also makes important investments in coordination and quality for these programs.

The Recovery Act also provides a \$5 billion TANF Emergency Contingency Fund, which is targeted to States that are serving an increasing number of needy families. During the recession, it is reasonable to expect that many States will temporarily expand their TANF programs to serve the rising number of poor families. The emergency fund provides an 80 percent Federal match to States with increased expenditures for basic assistance, non-recurrent short-term benefits, and subsidized employment. The emergency fund will enable States to provide time-limited, much-needed help for their citizens during this economic crisis, without undermining the work participation and other requirements of the 1996 welfare reform law.

Conclusion

The President's Budget strikes a new course for America. It presents the fiscal path with honesty, and deficits are projected to fall in half by the end of the President's first term compared to the deficit inherited by the Administration when it came to office in January

2009. Altogether, the policies in the Budget would reduce the deficit by \$2 trillion over the next ten years, begin to address the key contributor to the nation's long-term fiscal short-fall by proposing health savings measures that could help "bend the curve" on long-term health costs, and begin the process of health care reform.

The country faces grave challenges, both in terms of its short-term economic health and its long-term fiscal future, and working our way out of these difficulties will not happen overnight. The policies proposed in this Budget and those enacted last month in the Recovery Act and CHIP reauthorization represent important first steps on the path toward a high-performing health system and economic and fiscal health. I look forward to working with you in the weeks and months ahead to continue the process of addressing the challenges facing our nation.



FY 2010 Budget and Health Care Reform: Testimony before the Committee on Finance, United States Senate

Peter R. Orszag, Director
Office of Management and Budget

For Official Use Only

March 10, 2009



Reforming America's Health Care System: A Call to Action

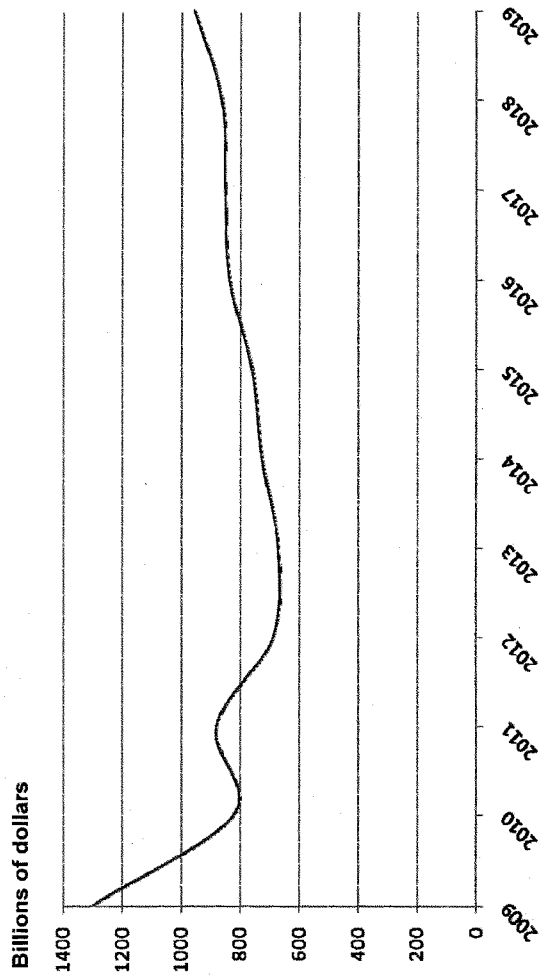
"The link between health care costs and the economy is undeniable."

"In 2009, Congress must take up and act on meaningful health reform legislation that achieves coverage for every American while also addressing the underlying problems in our health system. The urgency of this task has become undeniable."

***— Chairman Max Baucus,
Senate Finance Committee***



Inherited Budget Deficits

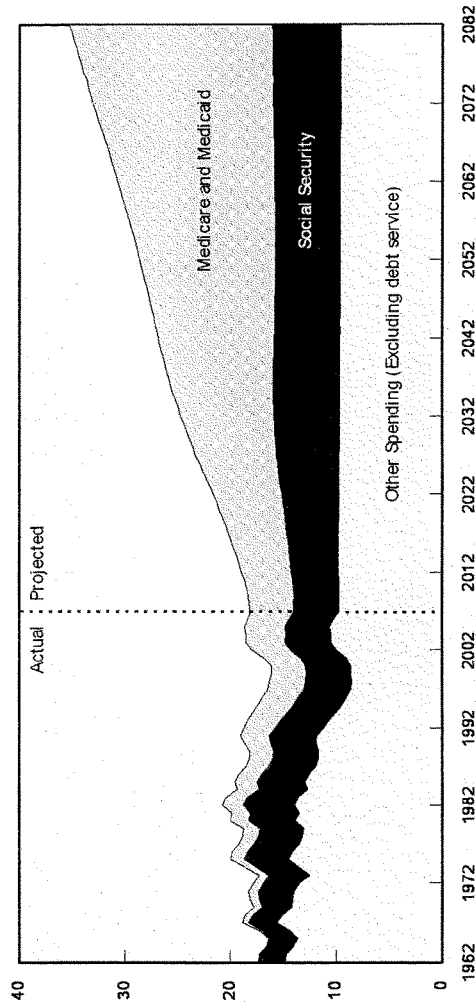


Note: Inherited projected deficits are the baseline projection of current policy minus the impact of the ARRA.



Long-Term Fiscal Gap and Health Care Costs

Percentage Share of GDP



Source: CBO



Excess Cost Growth in Medicare, Medicaid, and All Other Health Care

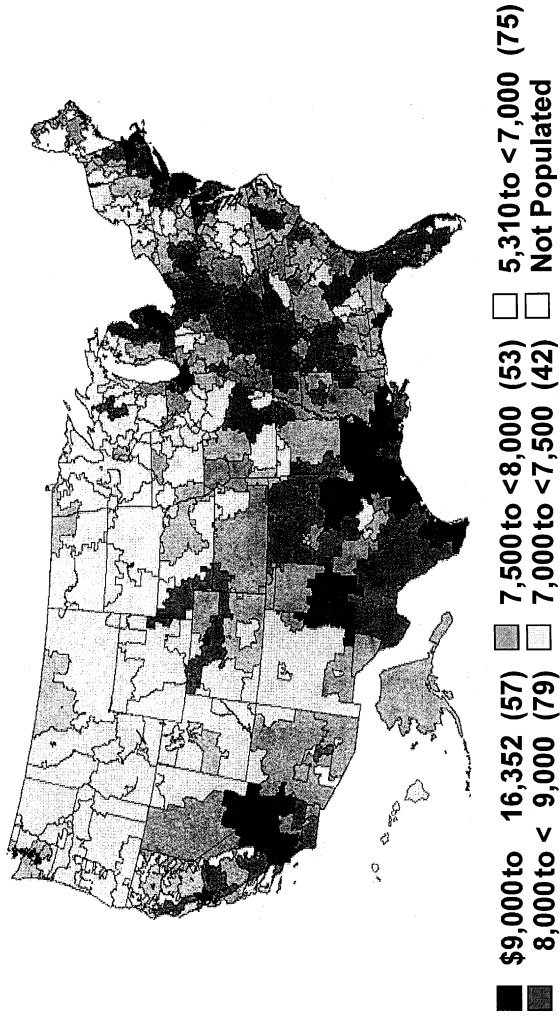
Percentage Points

	Medicare	Medicaid	All Other	Total
1975 to 1990	2.9	2.9	2.4	2.6
1990 to 2005	1.8	1.3	1.4	1.5
1975 to 2005	2.4	2.2	2.0	2.1

Source: CBO



Medicare Spending per Capita, by Hospital Referral Region, 2006

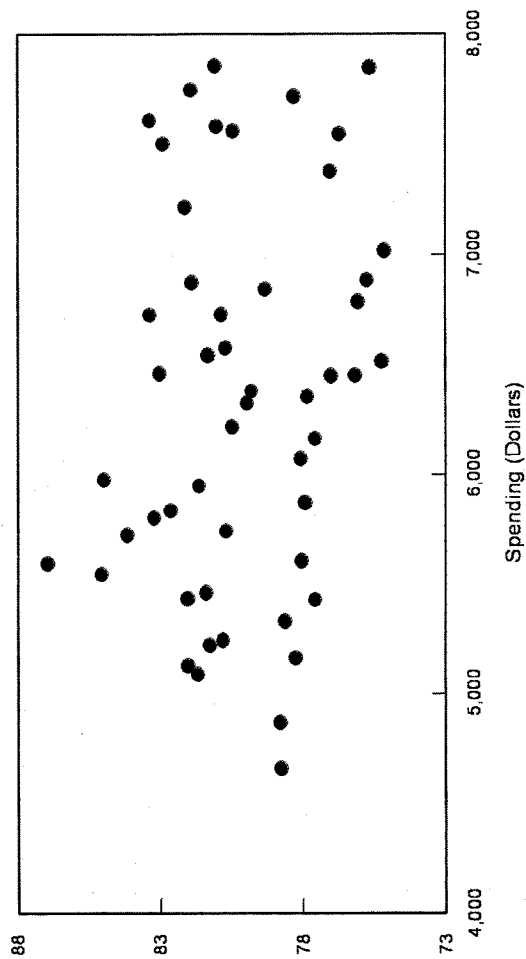


Source: www.dartmouthatlas.org



The Relationship Between Quality and Medicare Spending, by State, 2004

Composite Measure of Quality of Care



Source: Data from AHRQ and CMS



The Uninsured

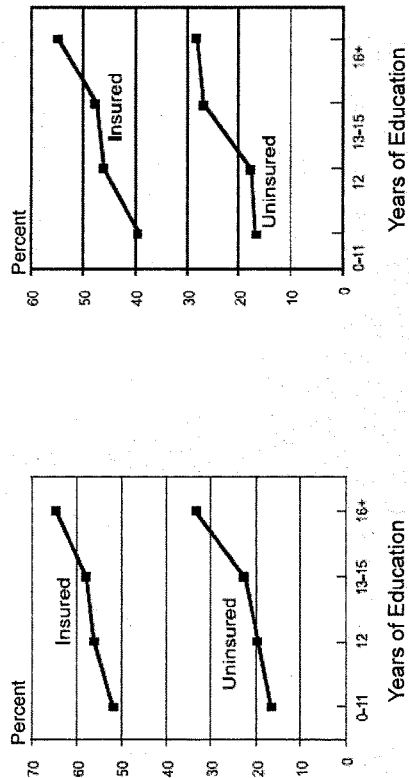
There are millions of Americans who have insufficient or no health care insurance.

- 45.7 million Americans are uninsured
- 86.7 million Americans were uninsured for some period of time during 2007 or 2008
- In 2007, nearly 70% of the uninsured lived in families headed by a full-time worker
- 8.1 million uninsured children
- In 2007, 17 million insured Americans spent more than 10 percent of their salary on health care
- 25 million Americans are underinsured, meaning that they do not have enough coverage to keep costs in check



The Uninsured (cont.)

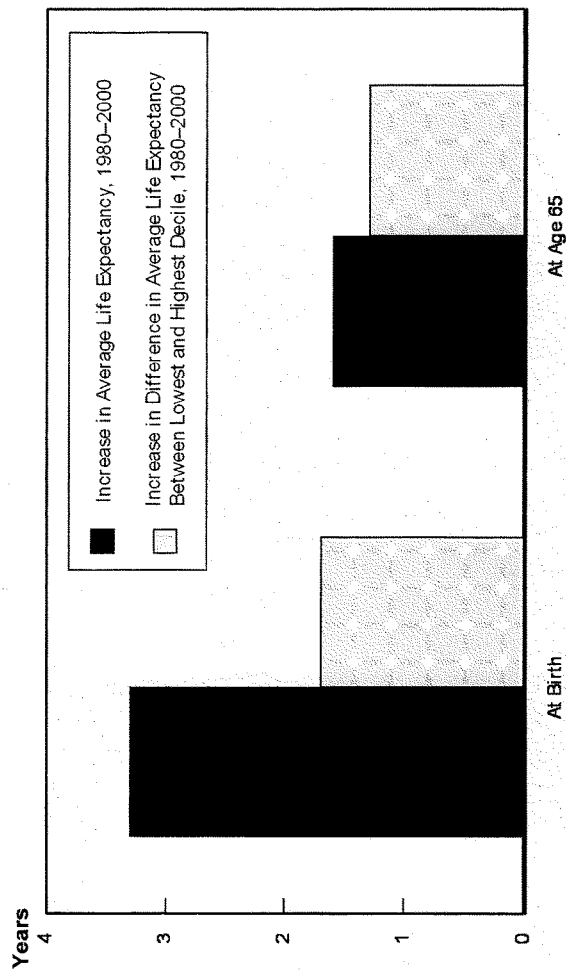
The impact of insurance and educational status among whites on having had a mammogram in the past year (left) or recommended colorectal cancer screening (right):



Source: Ward and others (2007)



Increase in Life Expectancy and Increase in Difference in Life Expectancy, by Economic Status



Source: Data from Singh and Siahpush (2006) and CDC



Eight Principles of Reform

The President looks forward to working with Congress to create and enact comprehensive reform to accomplish the following goals:

- Protect families' financial health
- Assure affordable, quality health coverage for all Americans
- Provide portability of coverage
- Guarantee choice of doctors
- Invest in prevention and wellness
- Improve patient safety and quality of care
- End barriers to coverage for people with pre-existing medical conditions
- Reduce the long-term growth of health care costs for businesses and government



Six Fundamental Steps Toward Reform

The Administration has already taken crucial steps to contain costs, expand coverage, and reform our broken health care system.

- *Reforms that stabilize the system:*
 - Signed CHIP to provide health care to an additional 4 million uninsured children on average in CHIP and Medicaid by 2013
 - Protected health coverage for 7 million Americans through COBRA



Six Fundamental Steps Toward Reform (cont.)

The Administration has already taken crucial steps to contain costs, expand coverage, and reform our broken health care system.

- Reforms that lay the groundwork for “bending the curve” over the medium to long term:
 - Invested \$19 billion in Health IT to help computerize Americans’ health records
 - Devoted \$1.1 billion in funding for comparative effectiveness research to arm physicians with data on what works and what doesn’t
 - Allocated \$1 billion for prevention and wellness interventions to help reduce the impact of chronic diseases and reduce costs



Six Fundamental Steps Toward Reform (cont.)

The Administration has already taken crucial steps to contain costs, expand coverage, and reform our broken health care system.

- *Reforms that enhance the size of our highly trained health work force:*
 - Allotted \$500 million in the Recovery Act (and have proposed an additional \$330 million in the Budget) for sufficient and well-trained doctors, nurses, and other health professionals



Commitment to Health

The FY 2010 Budget underscores the President's commitment to lowering health care costs and expanding coverage to all Americans by establishing a \$634 billion Health Care reserve fund over 10 years.

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	2010	2011	2012	2013	2014	2010-14	2010-19
Federal Health Savings	-1.8	-5.1	-18	-24.5	-34.3	-83.7	-316
Aligning incentives toward quality	0	-0.4	-1.3	-1.7	-2.1	-5.4	-20.5
Promoting efficiency/ accountability	-1.8	-4.3	-16.2	-22.2	-31.5	-75.9	-287.4
Encouraging shared responsibility	0	-0.4	-0.6	-0.7	-0.8	-2.4	-8.1
New Revenues	-	-11.1	-30.8	-33.5	-35.5	-110.8	-317.8
Subtotal: Reserve for Health Reform	-1.8	-16.2	-48.8	-58	-69.8	-194.6	-633.8
Additional resources and new benefits, to be determined with Congress							
Net Cost - Reserve Fund	0	0	0	0	0	0	0

Figures in billions of dollars



Aligning Incentives Toward Quality

The current health care system tends to reward quantity over quality. We can save money and increase quality of care by shifting this focus.

Improving care after hospitalizations and reduce readmission rates

- **ISSUE:** Nearly 18% of hospitalizations of Medicare beneficiaries resulted in readmission. Many readmissions are avoidable with the proper post-hospitalization care.
- **FY 2010 Budget:** Bundle payments to include the 30 days of care after hospitalization and penalize hospitals with high readmission rates*

* Readmission penalties would be for patients with targeted conditions who are readmitted within 30 days after their hospitalization.



Aligning Incentives Toward Quality (cont.)

The current health care system tends to reward quantity over quality. We can save money and increase quality of care by shifting this focus.

Expanding the hospital quality improvement program

- **ISSUE:** Evidence suggests that there is significant room to improve quality in hospitals
- **FY 2010 Budget:** Reward quality of care by linking a portion of Medicare payments for acute in-patient hospital services to hospitals' performance on quality measures.



Aligning Incentives Toward Quality *(cont.)*

The current health care system tends to reward quantity over quality. We can save money and increase quality of care by shifting this focus.

Reform the physician payment system to improve quality and efficiency

- **ISSUE:** The current payment system focuses on more care, not better care.
- **FY 2010 BUDGET:** Support comprehensive but fiscally responsible reforms to the payment formula



Promoting Efficiency and Accountability

Billions of dollars a year are wasted on inefficiencies in payment systems and administrative overhead. Streamlining these processes will make health care more cost-effective.

Reducing Medicare overpayments to private insurers through competitive payments

- **ISSUE:** Medicare overpays Medicare Advantage plans by 14% more than FFS on average.
- **FY 2010 BUDGET:** Replace the current payment mechanism with a competitive, market-driven system. This would save more than \$175 billion over 10 years and reduce Part B premiums.



Promoting Efficiency and Accountability (cont.)

Billions of dollars a year are wasted on inefficiencies in payment systems and administrative overhead. Streamlining these processes will make health care more cost-effective.

Reducing drug prices

- **ISSUE:** Prescription drug costs are too high and they are rising faster than CPI.
- **FY 2010 Budget:** Accelerate access to more affordable generic biologic medications and prevent collusion between brand name and generic drug manufacturers to ensure greater access to generic prescriptions.



Promoting Efficiency and Accountability (cont.)

Billions of dollars a year are wasted on inefficiencies in payment systems and administrative overhead. Streamlining these processes will make health care more cost-effective.

Improving Medicare and Medicaid payment accuracy

- **ISSUE:** Billions of dollars are lost to overpayments and fraud in the Medicare system. The Medicaid program is also susceptible to payment errors.
- **FY 2010 Budget:** As part of major program integrity efforts, provide \$31.1 million in FY 2010 to CMS to focus on program vulnerabilities, and to identify and reduce excessive and inappropriate payments. With a five-year investment of \$1.7 billion, about \$2.7 billion can be saved over that same period.



Next Steps

The Administration will explore all serious ideas that, in a fiscally responsible manner, achieve the common goals of constraining costs, expanding coverage, and improving quality.

OMB Director Peter R. Orszag, Responses to Questions for the Record from Senator Baucus (Senate Finance Committee hearing, March 10, 2009)

**Question for the Record from Senator Baucus #1
Federal State Partnership**

The President's Budget includes a proposal to create a new Federal-State Partnership aimed at improving the functioning of means-tested programs, including Medicaid, in an effort to achieve savings. The budget proposes funding of \$175 million in FY 2010 for the Partnership. However, little is known about the Partnership.

- **Dr. Orszag, I am curious to know more about the proposal to create a Federal-State Partnership.**
- **The Budget says that OMB will try to extract savings from means-tested programs like Medicaid through the Partnership, and I would like to know more about your plan.**
- **Please tell the Committee as much as you can about this new proposal.**

Response

The 2010 Budget requests \$175 million for the fund through an allocation adjustment. It will be used for agencies to develop pilots for programs that have some federal funding with a substantial State involvement; where States play a major role in eligibility determination or setting program rules and regulations; and which have high or persistent error rates or design issues. The Partnership does not target a specific program but will solicit proposals from agencies (in consultation with States) that have the goals of improving service delivery and outcomes for recipients, reducing erroneous payments or improving outreach. No programs are specifically targeted beyond the general guidelines above.

Examples of pilots that could be funded using this authority include process unification across multiple programs, data sharing between the federal government and States or across States, common application/eligibility determination, or leveraging best practices for eligibility determination, outreach, or verification from other programs or other States. Modification of program statutes is not included in the request but federal agencies are encouraged to utilize existing wavier authority or programmatic flexibility in designing the pilots.

OMB Director Peter R. Orszag, Responses to Questions for the Record from Senator Carper (Senate Finance Committee hearing, March 10, 2009)

**Question for the Record from Senator Carper #1
Health Savings/Flexible Spending Accounts**

Oversight of Health Savings Accounts, Flexible Spending Accounts, and similar programs seems to be left to the IRS, with little coordination with other agencies or groups to ensure that they are effective and accountable.

- **How significant are these programs in terms of the numbers of people affected by them and the impact they have on the budget? How vulnerable are they to abuse and exploitation?**

Response

These accounts are not a substantial part of the market. Survey data indicates that about 13 percent of firms offering health benefits offer a high-deductible health plan with a savings options. Other research has found that more than 6.1 million people have enrolled in HSAs, up 35 percent since 2007. HSAs accounted for an estimated \$1.14 billion in Federal tax expenditures in 2008.

**Question for the Record from Senator Carper #2
Nurse Home Visitation Program**

As Governor of Delaware, I helped implement early childhood prevention programs that improved the early health and development of children to reduce infant mortality, low birth weight and other problems that prevent children from growing up healthy and ready to learn. I was happy to see that the President's Budget creates the Nurse Home Visitation Program for first-time mothers as part of the President's Zero to Five Initiative. Delaware recently embarked on a similar initiative to implement a nurse home visiting program that helps low-income women get the medical and social care that they need to have healthy babies.

- **Can you talk more about the need to invest in these types of evidence-based, nurse home visitation programs?**

Response

Thank you for your work on these important issues. I look forward to working with you and your colleagues on the home visiting initiative. As you probably know, one nurse home visitation model has been rigorously evaluated over time and proven to have significant positive effects for first-time low income mothers and their children when the program is implemented with fidelity. Randomized control trials in multiple locations have shown long-term effects including substantial reductions in child abuse and neglect, preterm births, and arrests for both parents and children, putting estimates of its return-on-investment to the government between 3-6 dollars per dollar invested. There are also a number of other home visitation models that have

shown significant promise. Home visitation is an investment that can yield substantial benefits in the long term for children, families, and communities.

The Administration will provide additional information on the home visitation proposal will be provided as part of the detailed FY 2010 Budget. We look forward to working with the Congress to enact a program that helps our most vulnerable families give their children a head start in life.

OMB Director Peter R. Orszag, Responses to Questions for the Record from Senator Crapo (Senate Finance Committee hearing, March 10, 2009)

**Question for the Record from Senator Crapo #1
Medicare Advantage**

More than 50,000 seniors in my home State of Idaho rely on the Medicare Advantage program to provide them with health insurance. When previous Congresses decided to cut payments to earlier versions of the Medicare Advantage programs, the result was that many seniors in rural States lost the insurance they had. Eventually, Congress had to intervene and increase the payment rates to ensure that these seniors had access to a private health care option.

Given our experience with the program, how can you ensure that seniors in my State, and across America, won't lose their current health insurance and that we won't repeat mistakes of the past?

Response

The Administration believes in the importance of choice for Medicare beneficiaries. However, these choices should not be financed by significant overpayments by the Federal government. Accordingly, the Administration believes that Medicare beneficiaries should continue to have the choice of enrolling in Medicare Advantage plans, provided that the plans operate efficiently, provide quality care, and are paid appropriately by Medicare. The MA competitive bidding system proposed in the FY 2010 President's Budget would help achieve these objectives by better tying plan payments to actual costs, while still giving beneficiaries access to plan choices. Medicare currently pays MA plans about 114%, on average, of the amount a beneficiary would cost in FFS, according to MedPAC. These overpayments increase the Part B premiums paid by beneficiaries participating in traditional fee-for-service (FFS), worsen the fiscal sustainability of Medicare, and increase the burden on taxpayers.

A number of different proposals have been suggested to bring MA payments in line with the cost of providing services. The Budget proposes to use competitive bidding because this mechanism is more sensitive to local cost factors than other proposals. As a result, this approach will likely have different enrollment effects on rural and urban areas compared to other proposals. Preliminary HHS analysis suggests that the largest enrollment effects from competitive bidding likely would occur in areas where current plan bids are well below the current benchmarks. In these areas, the current overly generous Medicare subsidies provide plans with hundreds of dollars a month in extra benefits to entice beneficiaries to enroll. Under competitive bidding, the

average plan bid would be well below the current benchmarks in these areas and the amount of Federal payment per beneficiary would be significantly reduced. Comparatively, in low-cost FFS areas (for instance, counties that currently have benchmarks based on the rural floor payment), current benchmarks are likely to be higher relative to FFS costs. Under the proposal, benchmarks in these areas may remain above 100% of FFS, resulting in less significant payment reductions in low-cost FFS areas.

Question for the Record from Senator Crapo #2
Financial Markets

We agree that addressing health care costs is one of most important challenges we face as a country. However, the budget option book that you while at CBO shows just how difficult it is to turn the cost curve in the right direction. Your analysis, along with the example of Massachusetts, also demonstrates that insuring the uninsured will cost a lot of money. We therefore know that health reform will not pay for itself. Along with a \$630 billion down payment on health care reform, the Administration has included a placeholder (of \$250 billion) for up to \$750 billion in additional federal aid to financial institutions. All of this on top of a \$1.7 trillion budget deficit this year. At some point, this level of spending simply becomes unsustainable.

What gives you the confidence that the markets will support committing an estimated \$1.2 trillion in additional non-offset federal spending when our financial situation is at the most perilous point in a generation?

Response

Markets are currently investing in Treasury securities at historically low interest rates, indicating strong demand for Treasury securities. This strength of demand suggests that the markets will continue to provide the financing needed to support this temporary increase in spending.

In the current climate, the major concern in the markets is when the economy will turn around and the prospects for sustained economic growth in the future. The Administration is focused on advancing policies that will fuel economic growth now as well as in the long term.

Policy efforts include the multiple programs conducted under the Troubled Asset Relief Program (TARP) and the incentives to economic growth and job creation through the American Recovery and Reinvestment Act (ARRA). In addition, countercyclical programs such as unemployment compensation and Food Stamps have acted to cushion the effects of a shrinking economy and restore economic growth. The Administration is committed to taking additional steps as necessary to ensure that the goal of financial stabilization is achieved, and the budget includes a placeholder for these further efforts.

Looking beyond the current economic downturn, an important element of future sustained economic growth is getting health care costs under control. The Administration's plan to reform health care coverage will also focus on controlling rising healthcare costs. The reduction in health care cost growth over the long run through enacted reform will spur long-term economic

growth, as business, individuals, and all levels of government have a reduced financial burden for health care coverage.

Question for the Record from Senator Crapo #3
Comparative Effectiveness Research

Comparative effectiveness research holds real value for patients, but I'm very concerned that this could lead to centralized coverage decisions about who should and should not get access to medically beneficial care. We have seen this happen in other countries, like the U.K., where patients with breast cancer, kidney cancer, Alzheimer's and many other serious diseases are denied access to beneficial treatment options that are widely available in this country.

- **Do you share these concerns? What steps can we take to ensure this research achieves the goal articulated by President Obama – improving patient and provider decision-making – while avoiding these types of centralized access restrictions?**

Response

I agree that this research holds real value for patients, and understand your concerns about its use. The Administration is not proposing or seeking authority to apply comparative effectiveness information to limit the availability of health care treatments. Current efforts at the Federal level – including the \$1.1 billion included in the Recovery Act – are focused on increasing the quantity and quality of comparative effectiveness research produced to enhance medical decision-making by patients and physicians. This research will be widely available to give physicians access to the most up-to-date, comprehensive information on what treatment is likely to work the best for certain patients.

As research and medicine progress and more studies become available showing what works best for people with different genetic markers, patients should be better able to obtain individually-tailored information on treatments that maximize the likelihood of positive health outcomes. For example, pharmacogenomics is a field of research that studies how different people respond to the same drug based on their genetic makeup. Such research recognizes that what works best for one group of people may not be what works best for another group. More research comparing the effectiveness of different treatments for different groups of people should eventually lead to higher-quality health care.

Question for the Record from Senator Crapo #4
Medicaid Rebates

I'm concerned that proposals to increase the Medicaid rebate will cause cost-shifting to private payers – thereby increasing drug costs higher for employer-provided plans and other payers. CBO has noted that “although the Medicaid rebate program has lowered Medicaid's expenditures, it may have also increased the prices paid by other purchasers” by making it “more costly for drug manufacturers to offer price concessions to other purchasers if those concessions trigger the best-price provision.” As a result, CBO has found that the “large discounts offered by manufacturers have fallen substantially since the drug rebate program began.”

Do you acknowledge that increasing Medicaid rebates is likely to further increase cost-shifting and prescription drug costs for private payers? If so, do you still think it's a good idea to increase Medicaid rebates and why?

Response

The Administration's FY 2010 Budget includes a proposal to increase the basic drug rebate for brand-name drugs from 15.1 percent to 22.1 percent of the Average Manufacturer Price, which may help to reduce the effects of price-control-like mechanisms in the prescription drug market. Because the rebate amount is based in part off of the lowest price of a drug offered to any private purchaser, non-profit or government entity with certain statutory exceptions – a provision known as “best price” – drug manufacturers do not currently have an incentive to offer lower drug pricing in the private market because it increases their rebate obligation. Increasing the flat rebate percentage to 22 percent could mitigate the impact of best price by triggering that part of the rebate formula less often. This may actually encourage drug manufacturers to offer lower drug prices.

**Question for the Record from Senator Crapo #5
Deficit Reduction**

A chart provided by Director Orszag at the hearing (entitled “Inherited Budget Deficits”; on page 3) shows that the federal deficit in 2009 is approximately \$1.3 trillion dollars. The chart also shows that the deficit is projected to be \$650 billion by 2012. The note below the chart reads that “inherited projected deficits are the baseline projection of current policy minus the impact of ARRA.”

- **Accordingly, if we maintain current federal policies, will the deficit decrease by nearly half in this time frame?**

Response

Yes, in nominal terms, the deficit will decrease by nearly half in this time period under “inherited” policy – the baseline projection of current policy minus the impact of the American Recovery and Reinvestment Act. The Administration's proposed policies would cut the deficit by considerably more.

By the end of the President's first term, the Budget would reduce the deficit relative to current policy by about \$200 billion per year, and, over the next ten years, it would cut the deficit by a total of \$2.0 trillion relative to current policy.

OMB Director Peter R. Orszag, Responses to Questions for the Record from Senator Grassley (Senate Finance Committee hearing, March 10, 2009)

Question for the Record from Senator Grassley #1

On June the 28th, 2007, CBO economic and budget issued a brief from your staff had this quote about Medicare Advantage cuts. Quote, "would cause some plans to leave the program," end of quote. The brief went on to say, quote, "Rural areas would be effected more than urban ones," end of quote. So we have, in this budget, a cut of \$176 billion in Medicare Advantage through competitive bidding. Question, if we take \$176 billion out of this Medicare Advantage program through plan bidding, how many of the ten million beneficiaries enrolled in Medicare Advantage do you estimate would lose their current coverage? Also, how much of the \$176 billion in savings comes from decreased Medicare Advantage enrollment versus reduced payments to plans?

Response

In analyzing the Medicare Advantage (MA) competitive bidding proposal savings, it is difficult to distinguish the effects of the benchmark reductions compared to the enrollment changes. The amount of the savings attributable to each effect is dependent on the "stacking order", that is, which effect is assumed to occur first. That said, based on their methodology for estimating this proposal, the actuaries of the Department and Health and Human Services project that about 75% of the estimated savings from the MA competitive bidding proposal would occur from the payment reductions to MA plans, if enrollment were held constant. Thus, the remaining roughly 25% of the estimated savings would result from beneficiaries moving from Medicare Advantage to fee-for-service Medicare. Currently, about 10.5 million beneficiaries are enrolled in a MA plan. The actuaries' analysis suggests that, under the MA competitive bidding proposal, about half this many beneficiaries would be enrolled in an MA plan in 2016.

A number of different proposals have been suggested to bring MA payments in line with the cost of providing services. The Budget proposes to use competitive bidding because this mechanism is more sensitive to local cost factors than other proposals, for example, reducing benchmarks to a percentage of FFS spending. As a result, this approach will likely have different enrollment effects on rural and urban areas compared to other proposals. The preliminary HHS analysis suggests that the largest enrollment effects from competitive bidding likely would occur in areas where current plan bids are well below the current benchmarks. In these areas, the current overly generous Medicare subsidies provide plans with hundreds of dollars a month in extra benefits to entice beneficiaries to enroll. Under competitive bidding, the average plan bid would be well below the current benchmarks in these areas and the amount of Federal payment per beneficiary would be significantly reduced. Comparatively, in low-cost FFS areas (for instance, counties that currently have benchmarks based on the rural floor payment), current benchmarks are likely to be higher relative to FFS costs. Under the proposal, benchmarks in these areas may remain above 100% of FFS, resulting in less significant payment reductions in low-cost FFS areas.

OMB Director Peter R. Orszag, Responses to Questions for the Record from Senator Menendez (Senate Finance Committee hearing, March 10, 2009)

**Question for the Record from Senator Menendez #1
Nurse Visitation Program**

I am a strong proponent of proven early childhood prevention programs that improve the early health and development of children during their most formative stages because science tells us that these programs are cost-effective and have the greatest impact. That is why I was happy to see that the President's Budget creates the Nurse Home Visitation Program for first-time mothers as part of the President's Zero to Five Initiative. That is also why I will be introducing legislation that supports the Nurse Home Visitation Program. I look forward to working with my colleagues in Congress and this Administration to create this innovative program.

The creation of the Nurse Home Visitation Program will help low-income pregnant women get the medical and social care that they need to have healthy babies. It will not only improve the health, development, and school readiness of children, but also reduce child abuse, neglect, injuries, and juvenile delinquency of children while improving the economic stability of families to help break the cycle of poverty, strengthen the family structure and give children and families the financial security and sound foundation they need to thrive.

In my State of New Jersey, this new program will greatly facilitate the expansion of the nationally-recognized Nurse-Family Partnership, which after 30-years of rigorous, scientific testing, has been proven to save government resources by improving pregnancy outcomes, the prenatal health of infants, infant health and development, school readiness and maternal employment, while reducing child abuse, neglect and injuries.

- **Can you talk briefly about the benefits and cost-effectiveness of the Nurse Home Visitation Program and how it will allow States and the Federal Government to see a return on its investment in children and families?**
- **How important is it to have the highest evidentiary standard to ensure that the Nurse Home Visitation Program provides evidence-based services that save taxpayer resources?**

Response

Thank you for your work on these important issues. I look forward to working with you and your colleagues on the home visiting initiative. As you probably know, a nurse home visitation model has been rigorously evaluated over time and proven to have significant positive effects for first-time low income mothers and their children when the program is implemented with fidelity. Randomized control trials in multiple locations have shown long-term effects including substantial reductions in child abuse and neglect, preterm births, and arrests for both parents and children, putting estimates of its return-on-investment to the government between 3-6 dollars per dollar invested. There are also a number of other home visitation models that have shown

significant promise. Home visitation is an investment that can yield substantial benefits in the long term for children, families, and communities.

Additional information on the Administration's Home Visitation Proposal will be provided as part of the detailed FY 2010 Budget. We look forward to working with the Congress to enact a program that helps our most vulnerable families give their children a head start in life.

OMB Director Peter R. Orszag, Responses to Questions for the Record from Senator Stabenow (Senate Finance Committee hearing, March 10, 2009)

**Question for the Record from Senator Stabenow #1
Global Competitiveness**

Global competitiveness: I agree with our Chairman that we can address health reform as part of an economic recovery. To say otherwise is a false choice. We cannot afford to wait, given that 15% of Americans, or some 46 million, don't have health insurance, millions more are underinsured, and the growth in health-care costs has far outpaced wage growth and general inflation.

Last year, I was part of a panel sponsored by the New America Foundation where we debated the conventional economic wisdom that if the cost of health benefits rises, employers can easily and simply either cut wages or pass on those costs as higher prices to customers.

It seems to me that every dollar our companies have to spend that their overseas competitors don't have to spend puts us at a competitive disadvantage. That is a dollar that our competitors can use to lower their prices or invest in R&D. Additionally it would seem to me that our companies' health care costs are higher than the costs that foreign companies see in their taxes.

- **Can you help dispute the conventional economic wisdom and make the case why health reform needs to be a part of our economic recovery?**

Response

This is a time of great peril for our economy and for our nation's fiscal future. Our economy is in a deep recession, which threatens to be more severe than any since the Great Depression. The deficit is expected to reach higher and higher shares of GDP primarily because of rising health care costs. Over the medium to long term, the nation is on an unsustainable fiscal course. We need to act, and since the key to our fiscal future is health care, it makes sense to begin the process of putting the nation on a sounder fiscal path by tackling health reform. Spending on health care as a share of the economy has been growing and is expected to continue to do so in the future; total national health spending has increased from about six percent of GDP in 1965 to more than 16 percent in 2007. And between 2008 and 2018, average annual health spending growth is anticipated to outpace average annual growth in the overall economy by 2.1 percentage points per year. As a result, by 2018, national health spending is expected to account for just

over one-fifth (20.3 percent) of GDP. These projected increases in overall health costs drive the cost trends in our public insurance programs – which are themselves the primary driver of our long-term fiscal gap. Controlling health care cost growth is therefore the key to our long-term fiscal future.

At the employer level, rising health care cost growth can impede the growth of cash earnings for workers with employer-based coverage. As the costs of medical care increase, employers may find it difficult to offset their health insurance costs through reduced wages, and may instead reduce benefits or increase the costs (e.g., deductibles, premiums) paid directly by workers, which would result in more workers forgoing employer-based health insurance. Rising health care costs also make individual private coverage prohibitively expensive for more individuals. As health costs and premiums rise, so too does the number of uninsured Americans. The Administration supports fundamentally reforming our health care system to make our businesses more competitive and to ease a significant and growing burden middle-class families are bearing, while also improving the quality of our health care and lowering its cost.

Question for the Record from Senator Stabenow #2
Access to generic drugs

I was very pleased by the emphasis on generic drugs. The President's proposal will make the prescription drug marketplace more competitive.

I am interested in discussing further the ideas for increasing identified on page 28 and page 68, particularly the savings achieved. We are naturally going to have to identify a lot of savings as we craft that package, and improving access to generics will save consumers billions of dollars. A variety of agencies actually are involved in making our prescription drug marketplace more competitive from HHS and FDA to FTC's cases against anticompetitive agreements between brand and generic pharmaceutical companies that unduly delay timely consumer access to low cost generic drugs.

Looking at these issues affecting access to generics, has the Administration undertaken an analysis of just how much money would be saved by passing legislation addressing these issues? For example, has the Administration looked at how much savings would be if Congress passed something that would address the agreements that FTC has been fighting? Or authorized generics? If not, will it be undertaking any such analysis?

Response

The Administration recognizes that increasing access to generic drugs is an integral part of the overall strategy to improving public health and managing costs. For example, the Administration's FY 2010 Budget contained a proposal to establish a new regulatory pathway for the Food and Drug Administration to approve generic biologics, estimated to save the Federal government \$9.2 billion over 10 years. In addition, the Administration supports prohibiting "ever-greening", when brand name manufacturers reformulate existing products into new products to restart the exclusivity period, and anticompetitive agreements and collusion between brand name and generic drug manufacturers intended to keep generics off the market. The Administration looks forward to working with Congress to develop a comprehensive strategy to

give Americans better access to safe and effective medicines, including generic pharmaceuticals and biologics.

Question for the Record from Senator Stabenow #3
Employer Tax Deduction for Health Care

Employer tax deduction for health care: There has been much discussion about whether we should touch the tax code to help pay for reform. One debate is about how the tax code treats health care provided by an employer versus other methods.

How do we remove it partially – essentially capping the amount that is excluded from taxation – without adversely affecting those benefits that are high cost because of the characteristics of the enrollees?

Different industries and their workers may face different circumstances. For example, even if the Big 3 autos had health benefits like those provided to Toyota workers, Toyota's benefits would cost less than those for the Big 3, because they have a younger workforce and little or no retirees covered in their plan.

- So long as workers have different health care needs, how do we impose a cap that recognizes those differences?

Response

Many different ideas have been proposed to finance expanded health coverage. The Administration is open to all serious ideas that, in a fiscally responsible manner, achieve the common goals of constraining costs, expanding access, and improving quality. To achieve these goals and finance reform, the President looks forward to working with the Congress over the coming year.

Question for the Record from Senator Stabenow #4
Primary care/jobs

There is no disputing that health care has an effect on wages for many Americans, but it also helps create jobs for many others. We have to pay people to deliver care to the Baby Boomers for example. And as we are learning from the Massachusetts model, there aren't enough health care providers, particularly in primary care, to pay for the newly-insured.

Today, the U.S. health care system provides jobs for 14 million people. In my State, about one in every ten Michigan jobs is directly in health care. In March 2008, the U.S. Bureau of Labor Statistics that, while the nation continued to lose jobs on the whole, the health care sector continued to add jobs.

I was pleased to see that the President's budget calls for an additional investment (\$330 million) to recruit more young graduates to practice in areas with a health professional shortage.

Such investments are needed. In hearing from Michigan medical students, I know how debt and reimbursement are affecting their decisions on what and where to practice.

- **How can we also create incentives to move our health care workforce into primary care? How can we do this in a way that will not eliminate or dramatically cut jobs?**

Response

The Administration believes that a strong primary care health workforce is essential to an effective health care system. As you mentioned, the President's FY 2010 Budget invests \$330 million to place physicians, nurses, and dentists in underserved areas. Loan repayment and scholarships programs reduce graduate debt and provide incentives for students to enter primary care and practice in underserved areas. In addition to this investment, the American Recovery and Reinvestment Act provides \$500 million to address health professions workforce shortages, including \$300 million for the National Health Services Corps (NHSC). This funding will add 4,100 doctors, dentists, nurse practitioners and other professionals, and will effectively double the number of NHSC clinicians in the field today.

Question for the Record from Senator Stabenow #5
DME

I commend the agency, as well as the President's budget proposal, for taking steps to reduce the number of fraudulent suppliers in the Medicare program.

In recent years, CMS has undertaken numerous initiatives to combat fraud, waste, and abuse in the area of durable medical equipment (DME) under Medicare Part B.

- (a) But is there a concern that legitimate providers could be driven out of Medicare if complying with these requirements becomes too burdensome or costly?**

For example, many Medicare beneficiaries in my State rely on their local pharmacy for diabetes testing supplies and other durable medical equipment. Pharmacies are State-licensed and regulated by their State boards of pharmacy. They also typically have long standing relationships with both the Medicare and Medicaid programs.

But under a regulation proposed earlier this year by CMS, every pharmacy location will be required to spend thousands of additional dollars to comply with these new programs if they wish to continue to provide services to Medicare patients.

- (b) How can we ensure that oversight does not create additional barriers to participating in Medicare and therefore hurt patient access?**

Response

(a) The Administration is committed to reducing waste, fraud and abuse in all parts of the Medicare program, and also is mindful of balancing this commitment with the burden placed on Medicare providers to comply with program integrity initiatives. The Budget proposes to dedicate additional resources to program integrity activities that will enable the Center for Medicare and Medicaid Services (CMS) to more rapidly respond to emerging program integrity

vulnerabilities through an increased capacity to identify excessive payments and new processes for identifying and correcting problems.

In a 2008 report, the HHS Office of the Inspector General (IG) estimated the improper payment rate for DME services at 17.3 percent, compared to the 3.9 percent reported by HHS for the overall Medicare fee-for-service improper payment rate. In response to high improper payment rates for DME, CMS has taken multiple actions to root out fraud and improper payments to DME suppliers, including publishing a DME surety bond final regulation in January 2009 that will help reduce the number of fraudulent providers in the Medicare program by requiring that each DME supplier obtain a surety bond of \$50,000. Community pharmacies are included among the DME suppliers who would be required to acquire surety bonds. CMS estimates that obtaining a bond would cost an estimated \$1,500 per supplier annually. For legitimate DME suppliers, including community pharmacies, the surety bond requirement helps CMS know that these providers meet a certain threshold of compliance for participating in the Medicare program. Moreover, the surety bond requirement increases CMS' ability to recover improper or fraudulent payments made to DME providers, and helps to protect the Trust Funds.

(b) While not specific to DME supplies, according to MedPAC, more than 90% of Medicare beneficiaries reported good access to care in 2007. The Administration wants to encourage legitimate providers to participate in the Medicare program in order to maintain strong beneficiary access, and will continue to monitor beneficiary access to services as these initiatives are implemented.

Question for the Record from Senator Stabenow #6
Quality Improvement Demonstrations

I was very pleased that the President's budget requests funding for research at CMS on improving quality and efficiency without sacrificing access in Medicare and Medicaid. To me, this seems like an area of health care reform where we can achieve some of our goals by putting to work staff and equipment that hospitals already have, with some re-direction, versus having to add in new, additional resources.

As I have mentioned to you and in this committee, Michigan hospitals have been at the cutting-edge of quality improvement. For example, the Agency for Healthcare Research and Quality (AHRQ) is issuing a series of grants to ten State hospital associations over three years to replicate Michigan's Keystone quality initiative.

Just little things can have a big effect on patient safety. In another area of quality and reducing hospital-acquired infections, AHRQ identified using ultrasound to guide the placement of central lines as one of the 11 patient safety practices warranting widespread adoption. Using ultrasound as a guide actually reduced the complications of line placement by 78 percent.

Given that the costs of treating just line-placement complications can range from \$17,000 to \$45,000, one would think hospitals would have rushed to implement this change in how line placements are performed. But it hasn't happened.

- **Often it takes something like Keystone to make providers aware of best practices. For example, why aren't hospitals using their portable ultrasound machines at the patient's bedside for better placement?**
- **Could the provisions in the President's budget about expanding Medicare's demonstrations and pilot projects be used to create a national data registry on these types of safety practices and then the results used to expand the Hospital Quality Improvement Program?**

Response

The Agency for Healthcare Research and Quality (AHRQ) funds research aimed at improving the quality of health care and disseminates this information with the goal of influencing health care providers to voluntarily modify clinical practices based on the results of its findings. The Keystone Project is an example of research that produced dramatic results, and we hope this and other AHRQ research findings influence health care providers to modify their clinical practices to achieve the quality improvements demonstrated in these studies.

Research findings isolating clinical best practices are used by independent consensus bodies to develop quality measures, which CMS uses as the basis for quality data reporting. The President's FY 2010 Budget includes a proposal to build on the Hospital Quality Improvement demonstration to create hospital quality incentive payments that link a portion of payments to performance on quality measures. These measures could include process of care measures in order to encourage use of best practices. For example, hospitals paid under the inpatient prospective payment system are required to report on 44 measures in order to receive a full annual payment update in FY 2010. These measures could be used to determine hospital quality incentive payments, as discussed in the Centers for Medicare and Medicaid Services' "Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program." Many of these measures are based on implementation of best practices in processes of care, such as providing a prophylactic antibiotic within one hour prior to surgical incision. The measures reflect consensus among affected parties and, to the extent feasible and practicable, include measures set forth by one or more national consensus building entities such as the National Quality Forum.

COMMUNICATIONS



FOR IMMEDIATE RELEASE:
March 10, 2009

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STATEMENT
Of
The American Health Care Association & National Center for Assisted Living
for
U.S. Senate Finance Committee Hearing
on
The President's Fiscal Year 2010 Health Care Proposals
March 10, 2009

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL), which represents nearly 11,000 dedicated long term care providers, commend Chairman Max Baucus (D-MT), Ranking Member Charles Grassley (R-IA) and the members of this committee for addressing the President's Fiscal Year 2010 Health Care Proposals. As this panel considers expert testimony from Mr. Peter Orszag, Director of the Office of Management and Budget we hope that you keep one fact in mind – the majority of Americans will require long term care services at some point in our lives, which is why the FY 2010 budget must protect the healthcare and long term care services for our nation's most frail and vulnerable.

Long Term Care - A Healthcare Segment in Need of Reform

Americans are living longer and our nation's aging population is growing – many of whom have medical or cognitive conditions which require care in a nursing facility. Currently more than three million Americans rely on the care and services delivered in one of the nation's nearly 16,000 nursing facilities each year, with another 115,000 assisted living residents relying on Medicaid to fund their care and services. The forecast for the demand for long term care is alarming. It is projected that by 2040, as many as 9.3 million older Americans expected to rely on paid long term care services every year – in a nursing facility, and assisted living community or with paid home care – more than doubling current demand.

Given this reality, it is imperative that government, providers, advocates and consumers work together to ensure that America has a long term care system that meets the health needs of our frail and elderly, preserves choice in the care that is received, is cost-effective and is sustainable for the coming years when demand will dramatically increase.

In order to address these challenges, Congress and the Obama Administration must first fully appreciate the growing demand for long term and post-acute care and services for our nation's frail and elderly populations.

With the enormity of challenges facing our nation, the American Health Care Association and National Center for Assisted Living (AHCA/NCAL) supports President Obama's pursuit of fundamental reform to the U.S. health care system. Our current system is heavily reliant on government financing and is unsustainable in its present form.

Expanding Americans' access to high quality healthcare merits strong support and AHCA/NCAL encourage pursuing this goal in a way that avoids inadvertently limiting others' access to this very care. We believe that one essential objective of reform must be to ensure every U.S. senior and disabled citizen always retains ready access to quality long term care.

In the Administration's recently released Fiscal Year 2010 budget overview document entitled, *A New Era of Responsibility: Renewing America's Promise*, President Obama takes important initial steps to institute reforms to ensure our nation is prepared to care for our nation's next generation of frail, elderly and disabled Americans. We agree that reforms need to be initiated, but caution that any changes implemented address the increasing need for care and services among our nation's oldest and most frail citizens.

We strongly support the Administration's initiative to help address the shortage of caregivers by expanding nurse training programs. Without swift action today, we will not have the caregiving capacity in the future when demand will dramatically increase. However, we are concerned about other reform provisions within the FY 2010 budget overview such as efforts to "bundle" providers' Medicare funding. Upon closer objective examination, we believe this measure may have negative, unintended consequences on our patients, our front line care staff, and the long term care sector itself.

The long term care sector is a major driver of our nation's economy, contributing to the employment of more than 4.4 million individuals nationwide, supporting more than \$161 billion in labor income and generating \$56 billion in tax revenues. Because of the major role that the long term care sector plays in local, state and national economies, it is crucial that the President's final FY 2010 budget stabilize our economy, protect the care needs of seniors and the disabled, and create the new front line healthcare jobs that make a difference in the lives of seniors benefits every citizen.

Responsible Reform for Long Term Care

Recognizing the looming crisis in care costs, AHCA, NCAL and the Alliance for Quality Nursing Home Care partnered with Avalere Health to develop a comprehensive reform plan to address the need for change. The proposed model for reforming both financing and delivery of long term and post-acute care, which was released January 2008, is patient-centered, sustainable, and cost-effective. Some highlights of the plan include replacing the current patchwork financing with a voluntary federal system, the development of a new federal catastrophic long term care benefit, enhanced private long term care financing, and a streamlined post-acute delivery system. In short, our plan will provide a single, unified method for maximizing patient preferences and program value by ensuring that patients are cared for in the most clinically appropriate, high quality setting.

In the coming weeks, Avalere Health will be releasing an update to last year's reform proposal that will expand upon the existing plan and include conservative cost-estimates that illustrate how the comprehensive reform plan will provide budgetary savings over time.

While many recognize that change is crucial, far too often it is believed that we can delay implementing reform. While the demand for care will grow and the crisis will increase in the decades to come, today's system demands prompt attention and immediate action.

Moving forward within the context of this urgent health reform debate, we must focus on how to most efficiently fund the care needs of our senior's and disabled. Much important work remains to be done. As a starting point, such reform must always preserve access to care and assure quality as well as cost-efficiency. We look forward to working constructively with the Administration and Congress to ensure quality long term care is always the right of every American today, and in the years and decades to come.

As a significant driver of economic activity that has jobs available now – and more in the future as demand grows – it is critical that any final budget provides the financial stability for our sector so that we can provide the high quality care our nation's seniors require.

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**The Senior Citizens League
Statement for the Record
On
The President's Fiscal Year 2010 Health Care Proposals
Submitted to the
Senate Committee on Finance
March 10, 2009
Washington, D.C.**

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On behalf of the approximately one million members of The Senior Citizens League (TSCL), a proud affiliate of The Retired Enlisted Association (TREA), thank you for the opportunity to submit a statement regarding healthcare reform. TSCL consists of active senior citizens, many of whom are low income, concerned about the protection of their Social Security, Medicare, and veteran or military retiree benefits.

Our members are very concerned with the rising cost of healthcare for seniors. With skyrocketing Medicare premiums and out-of-pocket expenditures, coupled with a cost of living adjustment that does not accurately reflect the spending habits of the elderly, many seniors, or their caregivers, are forced to choose between life saving medications and paying for groceries or other bills.

Making healthcare affordable and accessible for all Americans—young and old—is of the utmost importance. However, we realize that there is an enormous price tag associated with this vision. Already, President Obama’s Administration presented a “down-payment” of approximately \$634 billion over the next ten years in its proposed budget for Fiscal Year 2010. Of this total, an estimated \$316 billion is expected to come from changes to Medicare payments and reducing fraud. With this in mind, TSCL encourages Members of Congress to support including the following items in any healthcare reform package.

TSCL and its supporters believe that substantial savings to the Medicare program could be gained with a few adjustments to current wasteful and abusive practices. Many groups, including the Government Accountability Office and Inspector General, have reported that the federal government is overpaying the Medicare Advantage (MA) insurers by about 14% or more. First, though, payments to Medicare Advantage plans should be re-evaluated by Congress. Additionally, the Centers for Medicare and Medicaid Services (CMS) should complete drug plan and MA plan audits as required by law. Plans should be required to refund overpayments, if any, to affected beneficiaries as well as the Medicare program.

TSCL believes that additional savings could result if consumer access to affordable prescription drugs is made possible by Food and Drug Administration (FDA) approval of the importation of safe prescription medications from selected countries. During the 110th Congress, the Congressional Budget Office (CBO) estimated that, if enacted, Senator Byron Dorgan’s (ND) Pharmaceutical Market Access and Drug Safety Act would result in a \$5.4 billion reduction in direct federal spending for prescription drugs and a \$5.2 billion increase in federal revenues over 2009-2017. The CBO also estimated that this legislation would reduce total drug spending in the U.S. by \$50 billion over 10 years.¹

TSCL adamantly opposes means testing and encourages Congress and the Administration to not expand it to Medicare Part D premiums. Monetary funds from a one-time high income (e.g. property sale, lump sum distribution of a pension account, etc.) or retirement savings should not be used to determine higher income based Medicare premiums for persons who would not normally be required to pay the higher fee. Because Part D plan premiums vary tremendously, implementation may be extremely difficult. Another challenge that could present itself is protecting beneficiaries’ sensitive tax information from misuse by private health plans.

¹ “Pharmaceutical Market Access and Drug Safety Act Frequently Asked Questions”
www.dorgan.senate.gov/issues/families/rx/faqs/.

In 2009, approximately 2.2 million affected seniors² pay at least \$38.50 and up to \$211.90 per month in addition to the standard monthly premium of \$96.40.³ This is the first year that beneficiaries pay fully phased-in higher premiums. Despite a ‘break’ in 2009, the standard Medicare Part B premium has increased from \$45.50 per month in 2000 to \$96.40—that is 111.8%! This percentage does not take into account the increases in premiums due to means testing. TSCL is supportive of legislation that would eliminate the means test applied to Medicare premiums. During the 110th Congress, Rep. Nita Lowey (NY) introduced H.R. 4330, which would have eliminated means testing for Medicare Part B premiums.

TSCL also supports legislative action that would either reduce or eliminate the coverage gap, often referred to as the ‘doughnut hole.’ For 2009, seniors falling into the gap must pay \$3,454 in out-of-pocket expenses before Part D coverage begins again. Factor in premiums, deductibles, and co-pays, the beneficiary must spend \$4,350 out-of-pocket before catastrophic coverage. Unfortunately, there are few Part D plans that offer gap coverage, and those that do typically cover only generic prescriptions.⁴ The beneficiary that takes a brand name medicine for which there is no generic or who takes a costly specialty tier drug(s) is often forced to choose between taking their meds and paying for other necessities.

Senator Bill Nelson (FL) introduced the Medicare Prescription Drug Gap Reduction Act of 2009, which, if signed into law, would amend the Medicare portion of the Social Security Act to reduce the Part D doughnut hole due to savings resulting from negotiated prescription medication prices. The federal government would be able to do such negotiations under the umbrella of Department of Health and Human Services (HHS), with its Secretary acting as a liaison/negotiator.

Included in the American Recovery and Reinvestment Act of 2009⁵ was approximately \$1.1 billion for Comparative Effectiveness Research (CER). Although language was included that stated CER should not be used by Medicare and private insurers to deny care or leave patients with uncovered costs, TSCL believes that this fact must be emphasized.

Take for example virtual colonoscopies. CMS is expected to issue a new rule that virtual colonoscopies will not be covered because there was “insufficient evidence” to conclude that virtual colonoscopy “improves outcomes in Medicare beneficiaries.”⁶

However, the public may be interested in receiving more information about available treatment options. The virtual type exposes patients to more dangerous levels of radiation than conventional methods. Currently, it is recommended that people get their first colonoscopy at age 50 and one every ten years thereafter, which means that a patient could

² “CMS Announces Medicare Premiums, Deductibles for 2009,” CMS, September 19, 2008.

³ <http://www.ssa.gov/pubs/10161.html>. March 9, 2009.

⁴ “Medicare Part D 2009 Data Spotlight: The Coverage Gap,” Kaiser Family Foundation, November 2008.

⁵ Public Law No. 111-5

⁶ “Cost Effectiveness of Colorectal Cancer Screening With Computed Tomography Colonography,” Medicare and American Cancer Society, April 23, 2007. “Medicare Blow to Virtual Colonoscopies,” Andrew Pollack, *The New York Times*, February 13, 2009, http://www.nytimes.com/2009/02/13/health/policy/13colon.html?_r=1&scp=1&sq=Medicare%20Blow%20to%20Virtual%20Colonoscopies&st=cse

receive three or four over their lifetime. The research could save lives and some people may prefer safer forms of treatment when possible.

CER could result in similar information about other medical procedures, which would be beneficial data for patients and doctors alike. However, TSCL fears that without proper oversight, CER could be eventually be used by Medicare and private insurers to deny treatment on the basis of cost-effectiveness despite the fact that every single patient may not have the same reaction to the same prescribed treatment. As such, TSCL recommends that legislators and the Administration ensure that CER is easily accessible by the entire U.S. public, and that it is used to help patients and their healthcare providers make informed decisions regarding medical treatment.

Another concern that many groups, including TSCL, and some legislators have is that CER may lead to age-based healthcare rationing. Presently, there is nothing set in stone that mandates limiting healthcare to persons on basis that he/she is too old to receive such a treatment and should accept the condition as something that comes with age. There are, though, hospitals that have adopted a type of healthcare rationing on basis of whether or not the patient has an outstanding payment balance or their legal status.⁷ Extending this practice to senior citizens is something that could happen and some argue should happen to help the federal government cut costs. TSCL believes that medical treatment should not be denied to anyone on the basis of his or her age. Again, CER managed by a federal healthcare board should be primarily used to help—not deny care—doctors, patients, and their families make informed decisions about the available treatment for that individual.

TSCL also strongly opposes changes to Medicare that would increase costs for beneficiaries. According to a recent TSCL survey, the overwhelming major of respondents said they are highly concerned about Medicare reform proposals that would increase out-of-pocket costs and at the same time would restrict what Medicare supplements or Medigap plans are allowed to cover.

Currently, most Medigap plans cover almost all of the deductibles and cost-sharing. Seniors and the disabled purchase the plans precisely because they need protection from the large out-of-pocket costs that Medicare does not currently cover.

Nevertheless, several budget options to control federal spending on Medicare, recently cited in testimony to the Senate Committee on Finance by the Congressional Budget Office would:

- Impose a new \$500 deductible for estimated three-quarters of Medicare beneficiaries.⁸
- Mandate coinsurance for certain services such as home health care that currently are not subject to cost sharing.
- Prohibit Medigap plans from covering the new deductible and restrict plans to covering only 50% of cost-sharing.

⁷ "Rationing Health Care Among the Uninsured: Practice Becomes More Common at U.S. Hospitals," Robert Bazell, Chief Science & Health Correspondent, NBC News, February 24, 2004.

⁸ "Options for Expanding Health Insurance Coverage and Controlling Costs, Statement of Douglas W. Elmendorf, Director Congressional Budget Office, Before the Senate Committee on Finance, February 25, 2009.

Beneficiaries could potentially face up to \$2,888 in out-of-pocket expenses (not counting premiums) in 2011 and the maximum out-of-pocket would increase every year after that.⁹

These proposals would prevent seniors from receiving the full supplemental coverage for their Medicare co-insurance and cost sharing that they pay for and rely on today. The media is full of stories about seniors who have been forced to file bankruptcy due to uncovered Medicare costs.

Seniors and the disabled already spend a larger portion of their incomes on health care than younger Americans. Thus, TSCL believes it would be poor policy to finance an expansion of healthcare coverage to younger Americans by shifting higher costs to the oldest and sickest family members.

There are countless additional provisions that will be debated, but one thing remains certain—beneficiaries should be protected and their health should come first. Protecting Medicare for current and future retirees is essential, and TSCL respectfully requests that any proposed changes impacting America's senior citizens be carefully considered.

⁹ Budget Options Volume I, Health Care, Congressional Budget Office, December 2008.

