

**A TIME FOR SOLUTIONS: FINDING CONSENSUS
IN THE MEDICARE REFORM DEBATE**

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WEDNESDAY, OCTOBER 12, 2011

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 2:01 p.m. in Room SD-562, Dirksen Senate Office Building, Hon. Herb Kohl, chairman of the committee, presiding.

Present: Senators Kohl [presiding], McCaskill, Bennet, Corker, Collins, Kirk, Heller, Moran, Johnson, and Chambliss.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

The CHAIRMAN. Good afternoon to everybody, and we thank you very much for being here today.

This year the debate in Washington has focused on our fiscal situation, and no one questions the need to do more to get our Federal budget under control. In addition to driving up the deficit, rising health care costs continue to drag down wages as potential increases are instead being spent on the increasing costs of health insurance and care.

While last year's health care reform was a start, it has not done enough to address costs. We need to do more and look at every opportunity to get health care costs under control.

Today I will be sending specific policy recommendations to the Joint Select Committee on Deficit Reduction aimed at reducing the cost of health care without pushing those costs onto consumers or limiting access to care. Several proposals to reduce drug costs were considered by this committee during a hearing in July. One proposal would allow negotiation of drug prices in Medicare Part D. In Wisconsin, we have already seen the tremendous savings that can be achieved through negotiation with the prescription drug program called Senior Care. This program has been incredibly effective and popular.

Other policies such as eliminating back-door payments for keeping generic drugs off the market have been considered by Congress for several years. These options could lead to significant reductions in government and consumer spending on health care.

We are also recommending to the Super Committee that drug manufacturers be required to provide Medicare Part B with the same rebates that Medicaid receives. The Department of Health and Human Services Office of Inspector General estimates that this

policy would have saved Medicare at least \$2 billion last year and could reduce spending overall by as well as \$24 billion over the next decade. I hope that the so-called Super Committee will consider these ideas carefully and incorporate them into their consensus deficit reduction plan.

So, once again, we are very happy that you're here today. In the longstanding tradition of operating as a bipartisan committee, today we will hold a hearing developed by the minority looking at opportunities to reduce health costs. I will not be able to stay for the entire hearing, so I will be leaving the gavel in the very capable hands of Senator Bob Corker, who is the ranking member of this committee. I know Senator Corker very well. I have come to develop a high regard and respect for him as not only a smart senator but as a senator who very much likes and wants to do things in a bipartisan way, working together not only with Republicans but also with Democrats, and so I respect the man. I know this is going to be a good hearing, but even more so, I respect him for who he is and what he stands for, what he's accomplished, and for what I'm sure he's going to do in the future.

Senator Corker.

STATEMENT OF SENATOR BOB CORKER

Senator CORKER. Mr. Chairman, thank you for those kind comments, and thank you so much for allowing us to have this hearing, and thank you for the way that you've led this committee. I know we'll have some more meetings before your departure, but I really do appreciate the way you conduct yourself and the way you conduct this committee.

With that, I rarely give opening comments, but I am today. I want to thank you all for being here. We want to discuss Medicare reform options, and I know that you all know that the Aging Committee has a responsibility to study Medicare and to make sure that serving our seniors well—that we're serving our seniors well and in a sustainable manner for future generations.

We're here to consider alternatives for controlling the long-term growth of Medicare spending, which was \$572 billion in 2011, and it's projected to be over \$1 trillion in 2021, a 56 percent increase in just 10 years according to the CBO Office of Baseline Expectations.

Financing this rate of spending growth by the Federal Government that is already borrowing 40 cents of every dollar it spends we all know is not sustainable. Future Medicare spending is projected to keep growing faster than GDP, and the Medicare trustees have said that the trust fund will be insolvent by the year 2024.

When you consider that an American family—and this is something that I don't think many people have been able to digest, but when you consider that an American family with parents both making \$43,500 a year, which is the average per-person income in our country, over their lifetime they will pay \$119,000 into the program when you include the employer contribution. So everybody knows that the employer pays one half, the employee pays the other half. This is in 2011 dollars.

They will receive, that same family will receive—remember they will pay in \$119,000, including the employer contribution, and the

benefits that they receive from Medicare are \$357,000. I don't think most Americans understand that is the math that we're dealing within Medicare. Obviously, that doesn't work, and this arrangement cannot continue and support the 20 million more Americans that are going to be on the program over the next 10 years, particularly when we're going to have the lowest number of people working per retiree that we've ever had in the history of our country.

If we keep putting off dealing with Medicare's \$38 trillion in unfunded liabilities, there will be severe consequences for the country. So we must start now and seize the opportunity before us with this Joint Select Committee on Deficit Reduction, and we see this hearing as an asset to that committee's work.

I have joined 42 senators, 21 Republicans and 20 Democrats and 1 Independent, in asking the Select Committee to go big, and I know that Maya MacGuineas with the Committee for a Responsible Budget has been a leader in all of that, to propose at least \$4 trillion in savings while also dealing with Medicare and entitlement reform, and tax reform simultaneously. If we start making significant changes now actuarially, they will multiply into huge savings down the road.

Ultimately, fixing Medicare and controlling the overall health costs will require transforming our health system so that we move away from the current fee-for-service program. It will be highly complex and could take decades to fully evolve, but this approach will actually slow the rate of health care spending, including Medicare, and lead to better outcomes for patients.

Medicare reform is a complex topic with diverse views, and I'm sure many people on this panel have very diverse views. I look forward to hearing the panel's recommendations, especially regarding options where members of both parties might find some agreement. Even if agreement can only be reached on smaller solutions, it would be a good first step in the right direction. Making progress on reducing Medicare spending—or the growth of it—will demonstrate that we are beginning to put our country back on a sustainable path. Medicare is America's largest fiscal and health care challenge, and getting more difficult to solve every day we don't address it. Now is the time to develop consensus around solutions to preserve the program for the 48 million seniors who rely upon it today, and the generations behind them who will in the future.

I look forward to an intelligent discussion, and I thank each of you for being here, and again, the Chairman for allowing this to happen. And I don't know, I think one of you may have an opening comment, both of you have an opening comment. Thank you.

STATEMENT OF SENATOR RONALD H. JOHNSON

Senator JOHNSON. Thank you, Senator Corker, and I'd like to thank my senior senator from Wisconsin, Senator Kohl, for having this hearing.

I'll keep my comments brief, but there are just a couple of points I want to make. Past estimates of what things are going to cost have not been particularly well done in the government, particularly in Medicare. When they first started this program back in 1965, they projected out 25 years and said that by 1990 Medicare

would cost \$12 billion. In fact, it ended up costing \$109 billion, basically nine times the original estimate.

Senator Corker, you said that by 2021 it should cost close to a trillion dollars. I mean, let's hope that's all it costs. So I think it's always important to keep in mind exactly what these projections really are versus what they end up being, two separate things.

The other comment I want to make is I don't fear addressing this issue. Certainly, as I traveled around the State of Wisconsin, when I ask younger people what do you expect to get out of Social Security and Medicare, younger people—unfortunately for me, that's people probably 50 and under—without exception, the answer is nothing.

Now, first of all, that's incredibly unfair. But the second point is to me that shows that there's a pretty receptive audience for structural reform because when you have no expectations of getting a benefit, you probably welcome the fact that if we reform these programs, make them sustainable, you'll get something.

So I think we should keep that in mind if we can just get past the demagoguery, because, quite honestly, nobody on our side of the aisle, I believe, is really talking about ending these programs. We're talking about making them structurally sound in the future.

So I agree with Senator Corker. What we need to do is look toward areas that we agree on and move the football forward in those areas first, and that's certainly what I hope to hear out of this hearing today. So, thank you.

STATEMENT OF SENATOR DEAN HELLER

Senator HELLER. Thank you, Mr. Chairman and Senator Corker, for this opportunity. Actually, I don't often give opening remarks either, but since this is my first time in this committee for a hearing, I would hope that you'd bear with me for a few minutes, and I'll keep it short.

I have to tell you, when I came over here to the Senate, I was pretty excited to serve on this committee and the impact that it has on seniors in my state that are facing some pretty difficult times. So thank you very much for the opportunity to serve on this committee.

Nevadans who depend upon Social Security and other Federal retirement programs are struggling following the lack of COLA increases in both 2010 and 2011. As a result, I hear almost every day from older Nevadans who are unable to keep up with the skyrocketing costs of essential goods and services.

In the next few days we'll hear about whether the COLA will be increased in 2012. An announcement concerning Medicare Part B for next year is also due out in the next coming week, couple of coming weeks.

Meanwhile, Americans who depend on Medicare are understandably concerned by all the talk coming out of Washington concerning these programs. Political posturing, baseless accusations have replaced constructive dialogue concerning the very real problems, that problem being the impending bankruptcy of Medicare.

I believe every senator in this room, every witness that we'll hear from today recognize that Medicare is on an unsustainable path. That doesn't mean we should scrap the program and start over,

and no one is suggesting that approach. Rather, we must build on Medicare's strengths, eliminating wasteful spending, fraud and abuse from the program and make sure its fiscal sustainability will outlast our children and grandchildren.

The message Congress must send to seniors and near-retirees is simply this: Medicare is a promise to American citizens that must be kept. Congress must do everything within its power to strengthen and protect this program, and I commend the ranking member for calling this hearing so this committee can take the lead on this important matter.

For my part, I'm a strong supporter of Medicare and have voted to prevent more than a half-a-trillion dollars in Medicare cuts during my time in Congress. I have voted against changes to Medicare that would impact current and near-retirees, including budgets proposed by members of both political parties.

Medicare is a program worth protecting, and that's why we're having this hearing today. Many solutions for the challenges facing Medicare have been proposed both within the Federal Government and from outside stakeholders, and I look forward to the witnesses' analysis of which plan provides a stronger future for Medicare.

Again, I'm grateful for the chance to discuss solutions to the challenges facing the Medicare program today. I thank the witnesses for taking time to share their expertise with us today and look forward to their testimony.

And with that, I yield back. Thank you.

Senator CORKER. Well, thank you very much. And again, Mr. Chairman, thank you for this.

I'll briefly introduce the witnesses, and we look forward to your testimony.

Maya MacGuineas is the President of the Committee for Responsible Federal Budget and Director of the Fiscal Policy Program at New American Foundation. She also advises the administration and regularly works with members of Congress on health, economic, tax and budget policy. I think many people have seen her on major broadcasts here recently as she's been very active.

Dr. Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy for the American Enterprise Institute. He's also Commissioner of the Maryland Health Services Cost Review Commission and a health advisor to the Congressional Budget Office. Before joining AEI, he was Assistant Director for the Health and Human Resources at Congressional Budget Office.

We welcome you.

Dr. John Holahan is the Director of the Health Policy Center for Urban Institute. He has done extensive work on state health policy, Medicaid, and issues of federalism and health. He has also helped develop the Massachusetts health care reform law.

Thank you for being here.

Douglas Holtz-Eakin, which is also seen often, is President of the American Action Forum and a commissioner of the congressionally-chartered Financial Crisis Inquiry Commission. He was formerly Director of the Congressional Budget Office and assisted Congress as they addressed numerous policies, such as the 2003 tax cuts and Medicare prescription drug bill and Social Security reform.

We look forward to your testimony. Again, thank you for being here.

STATEMENT OF MAYA MACGUINEAS, PRESIDENT, COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET AND DIRECTOR, FISCAL POLICY PROGRAM, NEW AMERICA FOUNDATION, WASHINGTON, DC

Ms. MACGUINEAS. Well, thank you so much for holding this hearing today. The fiscal challenges that we as a nation face are immense, and the long-term problems, of course, are driven primarily by growing health care costs. So this is perhaps the most important topic we could be discussing.

What was once a long-term problem has become far more immediate as debt levels have grown to near historic levels, and what I think is particularly troubling is that they are expected to grow indefinitely. The debt is already presumably at a level where it's harming economic growth in this country. So as we struggle to figure out how to grow the economy, bringing our debt levels down will be a key to all of that.

So I'd like to make four main points today as we go over the different options for controlling health care costs, and Medicare in particular. There are many areas of overlap between a variety of fiscal plans on ways to save money in health care, and as many of them as possible should be implemented as quickly as possible, particularly because they will all phase in rather gradually, and you want time for the savings to grow.

No matter how large a package that we manage to put in place, it is in all likelihood will not be sufficient to bring down health care costs. And unlike something like Social Security, which we know how to fix, it's just a question of choosing which levers to pull, health care reform is going to be an ongoing process. So again, we want to get as much done as possible, analyze the results, and then go for the next round as soon as we're able to.

We should put in place policies that are likely to generate savings even if they don't score, "score well," or they don't generate large savings immediately, because they will compound. We should end the open-ended nature of spending on health care reform, through health care reform, and consider including it in a budget as we do all other national priorities. And then finally, just on the point, Senator Corker, that you brought up, on the notion of going big, we know that we have a major fiscal problem to face, to fix in this country, and we know that in order to do that, everything is going to have to be on the table. And to get everything on the table, structural health care reforms really have to be the centerpiece of that because that's the largest problem that we face. So the sooner we start considering those, the sooner we get to the point of acknowledging that all parts of the budget are going to have to be part of a fiscal fix.

So I'll touch on a variety of reform options, and I broke them into things that I called savers, benders, and architectural reforms. Most of these reforms enjoy support of a number of different proposals, and I've included an appendix in the back of my testimony which hopefully will be helpful which compares the major plans and all the health care reforms that they have in it.

We also have a broader comparison table of all the different areas, so health care and also the other areas of the budget that I can submit to anybody who is interested.

So first looking at savers, savers would bring down the levels of health care spending, and though growth might be the same, it would be off of a lower base. These would include things like raising the Medicare eligibility age, something that's now possible in a way that wasn't before because of the introduction of the exchanges and something I think should be considered strongly; reducing and reforming payment rates for home health care providers, skilled nursing facilities, rural hospitals, hospital payments for bad debts, and graduate medical education; reforming pharmaceutical drug payments, which was talked about in the beginning of the opening statements; and further means testing premiums for Medicare Part B premiums or raising the basic Part B premium across the board.

The next category is benders, and those would bend the health care cost curve by bringing down the growth of health care costs, as well as the level. These might include things like greater cost-sharing requirements in the form of deductibles and copayments. Also, limiting Medigap or other supplemental insurance would provide better incentives for those participating in these programs to become more cost conscious.

Finally, we could overhaul the entire cost-sharing system by, for example, replacing all of the cost-sharing rules in Medicare Part A and Part B with a single deductible and co-insurance up to a cap. I have to say, I think some of these are the most promising changes and that they get into structural reforms without changing the overall system at this point in the national health reform discussion.

We could speed up adoption of successful cost control pilots which were included in the Affordable Care Act as we're able to assess them and see which ones lead to proven results. We could cap non-economic and punitive damages in medical malpractice. And finally, coordinating care of dual eligibles or those who are eligible for both Medicare and Medicaid can lead to cost savings.

So then, finally, the architectural reforms, and these are the changes that would change the basic structure of the Medicare system by ending the basic design of open-endedness on health care spending.

So there are a variety of ways to do this. They could include expanding IPAB to include cost-sharing rules, provider payment reforms and benefits, or even overall spending, so expanding the kinds of things that IPAB is allowed to discuss and make recommendations on.

Premium support or competitive bidding. Under premium support, the Federal Government would provide subsidies to individuals to help them purchase health insurance in private markets, and a variation of pure premium support would be to introduce premium support alongside a traditional Medicare system as was recommended in the Domenici-Rivlin Commission, which is also something I think is an idea really worth looking closely at.

Competitive bidding would allow private plans to compete alongside Medicare in the new health care exchanges in which tradi-

tional fee-for-service Medicare would offer health plans in tandem with private bids, thus providing more price competition.

And then finally, a budget for Medicare. The bottom line, I think, is that restructuring health care spending, we will sooner or later realize we cannot keep this open-ended commitment to health care, and we need to figure out the most efficient, effective and fair way to cap or limit spending while protecting people who depend on these programs.

So while Medicare can and must play a critical role in controlling health care costs, going forward Medicaid, TRICARE, Federal Employees Health Care Benefits, and ACA and the health care exclusion in the tax code are also all other areas that we should consider for savings.

So I'll close here. I again really appreciate your holding this hearing and the bipartisan nature of it, and I look forward to the discussion. Thank you.

[The prepared statement of Maya MacGuineas appears in the Appendix on page 39.]

Senator CORKER. Thank you.

Mr. Antos.

**STATEMENT OF JOSEPH ANTOS, WILSON H. TAYLOR SCHOLAR
IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC**

Mr. ANTOS. Thank you. Medicare reform is an essential part of any plan to rein in the Federal budget deficit and stabilize the national debt. Medicare spending will double over the next decade. Indeed, that trillion dollar estimate is optimistic. It assumes that substantial price cuts on providers in Medicare will actually be taken over the next 10 years.

The first of the baby boom generation turned 65 this year and enrolled in Medicare. Over the next two decades some 70 million people will move out of the workforce, into retirement, and into Medicare. That will place an increasing burden on the budget and on younger generations whose taxes support the program.

The Budget Control Act creates an opportunity for Congress to act. The Joint Select Committee on Deficit Reduction is charged with developing a plan that could reduce the Federal deficit by at least \$1.2 to \$1.5 trillion over the next decade. The committee shouldn't stop there. Higher levels of deficit reduction that are maintained over the long term are necessary for fiscal stability.

A realistic Medicare reform package that could be considered by the Joint Select Committee must yield substantial program savings within the 10-year budget window as scored by CBO. That favors provisions that could be implemented fairly rapidly and whose capacity to reduce program spending is reasonably clear. At the same time, however, at least some provisions must be forward-looking and ultimately risky. Business as usual with a few tweaks will not be effective in preserving Medicare for the long term.

I also have three categories. Probably everybody has three categories of options. I look at the near-term options, the options that you could implement fairly quickly that CBO will likely score favorably. There are two categories there, supply oriented options, de-

mand oriented options, and then the longer-term investments in real reform that get at the heart of Medicare spending challenge.

On the question of supply oriented options, most of the proposals that you see coming from the White House and coming from various commissions have a raft of price reductions and other kinds of fee-for-service hits on providers. That's inevitable. CBO will give you a score on that. However, to argue that Medicare cuts of that nature on providers are painless is incorrect. The fact is that no cut is painless. Somebody endures some pain, and ultimately it is the beneficiary that we have to be concerned about.

So if we have repeated massive cuts in provider payments, we will see negative impacts on beneficiaries in terms of access to care and in terms of medical technology and innovations that are necessary to produce cures that we all hope exist in the future.

On the demand side cuts, the sorts of things that Maya just mentioned are all I think highly relevant. Those sorts of things—reforming Medicare's cost sharing, for example—makes a lot of sense. Going after Medigap and requiring that every Medicare beneficiary have to pay some amount for at least the basic services is a sound economic principle and encourages people to pay attention to the services that they get.

A more promising avenue is looking at where the money is really spent in Medicare. Ten percent of Medicare beneficiaries account for 60 percent of the spending, and we can do a better job. This is a harder thing than just adjusting the rules as they are now.

We can do a better job of bringing in chronic care management and focusing it on the people who are the big spenders. If you apply that to people more generally, you're just not going to get a cost-effective result. So we need to focus on the big spenders in Medicare, not just the big spenders on the supply side but the big spenders in terms of Medicare beneficiaries.

We need essentially to create a coordinated care system that's virtual, since the traditional Medicare program can't actually produce it. Actually, we can still do a good job there.

And then finally, longer term reform. Medicare's uncapped entitlement and fee-for-service incentives have driven a steady but unsustainable rise in program spending. Both patients and providers benefit from increasing the use of more effective and more expensive treatments, and workers are stuck with the bill. Neither patients nor providers have much incentive to hold down costs to provide services in the most efficient way, and the reason for that is the basic structure of the entitlement. Essentially, providers know that if they provide more services, they will get more pay. Patients know that essentially everything is covered. So in that case, why would anybody turn anything down?

What we need to do is we need to set up a reimbursement system so that everyone has an incentive to make prudent, efficient choices. If you try to work only on the supply side, you're working with one hand tied behind your back. You need to enlist the aid of patients as smart shoppers. You need to get providers to recognize that they face a budget constraint and they need to find better, more efficient ways to provide services rather than to just provide more services.

Thank you.

[The prepared statement of Joseph Antos appears in the Appendix on page 51.]

Senator CORKER [presiding]. Mr. Holahan.

STATEMENT OF JOHN F. HOLAHAN, DIRECTOR, HEALTH POLICY RESEARCH CENTER, URBAN INSTITUTE, WASHINGTON, DC

Mr. HOLAHAN. Thank you. Thanks for the opportunity to testify before the committee. I appreciate that you're having this hearing.

In this testimony I'd like to make three points. Three seems to be the magic number here today. First, Medicare spending is projected to grow at about 6.5 percent per year over the next decade. This is faster than the growth in GDP, which is 4.7 percent per year. Much of this is due to the projected increases in enrollment, which is about 3 percent per year, which is going to occur because of the retirement of the baby boom generation.

On a per capita basis, spending is projected to grow at 3.5 percent. It goes up to 4.2 percent with the physician fee fix, but this is close to the increase in GDP per capita, sort of more or less the target that people have been after.

Spending growth in Medicare is really projected to be relatively low by historical standards. This is happening because of the retirement of the baby boomers bringing a low-cost population into the Medicare program, essentially changing the composition of enrollees towards the lower-cost one, and because of provisions in the Affordable Care Act that have reduced Medicare spending increases. But clearly, still more needs to be done.

The second point is that proposals to privatize Medicare, such as Congressman Ryan's and others, we don't think will work as intended. The idea is to have Medicare provide subsidies towards the purchase of private plans, people being responsible then for the additional cost above the Medicare payments. The idea is that beneficiaries would respond by choosing plans with higher deductibles and cost sharing and use less services.

The CBO has estimated that Federal spending will actually decline because of the way the payments are indexed, but beneficiary costs will increase greatly, and the total cost to the nation of providing Medicare benefits would also increase. CBO has estimated that average spending will be 28 percent higher under private plans than under Medicare in 2022. CBO finds that private plans are more costly than traditional Medicare because of higher administrative costs and higher provider payment rates. Simply because of the way the health care market works, you need a strong buyer with leverage over providers, and payment rates in Medicare has it to a greater degree than private insurers.

The second issue is that privatization approaches ignore the fact that 20 percent of Medicare beneficiaries account for 77 percent of spending. Most of these will have spending among any plausible out-of-pocket caps you're likely to see in private plans. That's most of the high spenders will face virtually no out-of-pocket costs for most of their spending, which will limit the impact.

But there are many other policies that could be pursued that are short of a major restructuring that will provide a considerable amount of savings and put Medicare on a lower expenditure path.

The demonstration programs that are testing things like medical homes and accountable care organizations should be pursued aggressively and moved and expanded as fast as possible to the extent that they prove to be successful.

CBO and MedPAC have made a number of other recommendations. These include reducing home health and skilled nursing facility payments, which could yield savings of about \$40 billion over 10 years. CBO has proposed an increase in cost-sharing for home health services, with estimated savings of about \$50 billion over a decade. The Bowles-Simpson Commission has recommended extending Medicaid drug rebates to Medicare dual eligibles. Others here have, too. Savings are estimated at \$49 billion over 10 years.

Next, the Medicare premium structure could be altered to lower premiums for low-income beneficiaries and increase them for those above 300 percent of poverty. The current structure makes no sense. Our idea would be to create a premium schedule much like that in the Affordable Care Act that increases premiums as incomes increase.

In a somewhat similar proposal, CBO has estimated savings of \$241 billion over 10 years by increasing the Part B premium from 25 to 35 percent of program cost. This is similar but doesn't have the low-income protections that we think are necessary. So if you put that in, savings would be lower.

We also think Medicare cost sharing could be restructured with a single deductible, and most importantly an out-of-pocket cap on all spending; and further, that prohibiting Medigap policies from covering the first \$500 of cost sharing and limiting coverage to 50 percent of the next \$5,000 we think are good ideas. This will make Medigap coverage less attractive, less necessary, and save about \$110 billion over 10 years.

Another option we think should be looked at is increasing the age of eligibility to age 67. This option is feasible once the ACA is fully implemented. The ACA provides for age rating and income-related premiums and cost sharing. Low-income people 65 and 66 would actually pay less under the ACA than they would under Medicare today. There would be shifts, however, to those with higher incomes, to employers, to states. Subsidies and exchanges would be higher. Even after accounting for these shifts, CBO has estimated that such a policy would reduce Federal outlays by \$125 billion over a decade.

Finally, Medicare should take greater responsibility for the acute care services provided to dual eligibles. Most of the acute care services used by dual eligibles are paid for by Medicare, and most successful demonstration programs have reduced utilization of Medicare services, not Medicaid. Thus, Medicare, not Medicaid, should take the lead role in developing policies to manage these acute care services of dual eligibles. Spending we estimate for 2010 is \$305 billion, over a decade is over \$4 trillion. So even small reductions in spending would yield savings of over \$200 billion over 10 years.

So all of these things taken together would reduce Medicare spending substantially and I think achieve what you want. Thank you.

[The prepared statement of John F. Holahan appears in the Appendix on page 63.]

Senator CORKER. Thank you for your testimony.
Doug.

**STATEMENT OF DOUGLAS HOLTZ-EAKIN, PRESIDENT,
AMERICAN ACTION FORUM, WASHINGTON, DC**

Mr. HOLTZ-EAKIN. Ranking Member Corker, and members of the Committee, thank you for the chance to be here today. And for the record, I wanted to thank the Chairman for his service and congratulate him on his tenure in the Senate. I've had the privilege of being at this committee under his chairmanship before.

I wanted to add my voice to those that stress the absolute imperative that Medicare be reformed. At the moment, the gap between payroll taxes and premiums paid in and outlays headed out is \$280 billion a year, and it will rise to \$600 billion over the next decade. It's an extraordinary fiscal cancer, and under current law there are threats above and beyond the dollars at stake.

If you take, for example, the Independent Advisory Board, it will by its very nature be given targets for cutting Medicare spending that must be reached within a year. It will inevitably be driven to reducing reimbursements for particular services or devices or drugs. My fear is that it will, in the process, target the most expensive, newest, most innovative treatments and will act as essentially a random tax on innovation. In the process, the program will become undesirable to the very beneficiaries it's meant to serve.

And so we need to change the fiscal stance of this program, but we need to do it in a way that makes it durable and serves the beneficiaries well and not disguise short-term budgetary success with actual progress toward the long run, and I think that's the great challenge that we face at the moment.

I, in the spirit of the day, have in my written testimony, which is submitted for the record, many of the same savers and benders that Maya categorized, the cost sharing and things like that. I won't belabor them. I look forward to having a discussion about what might actually work.

But I also included some things that from a budgetary point go the wrong way but we need to fix. Certainly, the SGR is a broken mechanism and is among the things that is wrong with Medicare at the moment, needs to be fixed. It is budgetarily expensive, but I don't think we can pretend it's not there. Those are monies that are quite likely going to be spent. We're just pretending they're not, and we need to acknowledge that.

And we also need to fix the CLASS Act. The CLASS Act is simply unsustainable. It is a dangerous fiscal innovation for the United States. It should be repealed immediately. It would be scored as widening the deficit, but I think it would be an improvement in policy and ought to be on the radar screen of the Joint Select Committee.

Finally, I want to again stress the imperative of having the near-term changes be steps toward a long-run sustainable future, and in my testimony I embrace the idea of moving toward a system of premium support. I do that for a number of reasons. The first and most one is it is, in fact, a budget constraint on Medicare. It caps the taxpayers' exposure to this program and eliminates the incentives that I think Joe Antos described quite eloquently, which is

one in which beneficiaries and providers jointly have absolutely no regard for how much money they spend and have good incentives to behave that way. And we need to stop that, provide incentives for efficiencies and high-quality outcomes.

I believe that a well structured premium support can do that. It will have a competitive nature that is missing. It would look closer to the Part D program, which is the best of our entitlement programs at the moment and I think would be a step toward the right direction. It would also place the responsibility and the opportunity for real innovation and quality improvements in Medicare in the private sector where I believe elsewhere in the economy we have seen a better track record of success.

And so while there are many ways to put Medicare on a budget constraint over the long run, I think that's one that the committee ought to look at very carefully.

We've seen pilot proposals and full-fledged proposals. My take on those is they are less exposed to the dangers that Mr. Holahan mentioned in terms of out-of-pocket costs for beneficiaries. Work that is underway at my think tank suggests that the CBO extrapolation is just that, an extrapolation. It misses some important market forces, and I would look forward to working with the committee in thinking about that kind of a proposal.

So thank you for the opportunity to be here today, and I look forward to your questions.

[The prepared statement of Douglas Holtz-Eakin appears in the Appendix on page 71.]

Senator CORKER. Well, thank you all for your testimony. It's outstanding. We have, along with great witnesses, a lot more full participation than we normally have. And so I'm going to let actually all of you ask questions first, and I'll do that at the end.

Senator Bennet, and then go to Senator Collins.

Senator BENNET. Thank you, Senator Corker, and thank you very much for holding this hearing and inviting us all to be a part of it, and to the panel for your excellent testimony, and I mean that. I don't always say that. I appreciate it.

I wanted to get your thoughts on sort of a broad question, which is that there are isolated examples of excellent quality at lower prices that are throughout the delivery system in this country, but it seems that they occur sort of in spite of the way the Medicare incentive structure works rather than because of the way the Medicare incentive structure works. These are places in my own state like Denver Health. They are places like St. Mary's Hospital in Grand Junction. Both of them are managing to deliver high-quality care at a lower cost. Neither of them have a hammer and sickle hanging outside of them. They're just doing what quality organizations do, electronic medical records, the doctors are salaried, accountable care work, transitions and so forth.

What is it about the Medicare incentive structure that has made delivery system reform so difficult? What can we change to accelerate the innovation that we need to see in our health care system? Because otherwise I don't think most of the proposals that I've seen on Medicare are actually going to solve the budget problem that we face, because fundamentally what we've got is a cost problem in the delivery system itself, and until we are actually able to address

that, I don't think we're going to make meaningful progress on this question.

Mr. Holtz-Eakin.

Mr. HOLTZ-EAKIN. I think at the broadest level there are two very big contradictions inherent in the Medicare system. The top level one, the one that Joe Antos mentioned, is we essentially say to beneficiaries you may have all of the finest medical science that America can produce at low or no cost, and that turns out to be really expensive. So then we go to providers and we say stop that, either literally or by cutting their reimbursements to the point where they do, which violates our pledge to beneficiaries they can get all they want. And that inherent contradiction will never go away until we put the system on a budget and say you providers and you beneficiaries, these are the resources you have; let's provide some efficient quality care. That's contradiction number one.

Contradiction number two is we pay hospitals based on DRGs, and we say here's some money, go treat people, and with some exceptions they're basically given the incentive to do as little as possible to treat people, and that has dangers on the quality front. At the same time, we have doctors being paid on volume. Fee-for-service medicine rewards that. Our doctors practice in hospitals, and only a few of them are the doctors and the administrators not at war, and it's not a surprise. We pay them, and it's fundamentally contradictory. And so we need to get them on the same page with reimbursement systems that bundle their incentives.

Mr. HOLAHAN. I would respond in a couple of ways. One, as I said in my testimony, one of the big things we're facing now in Medicare spending growth is the growth of enrollment, the baby boom generation. We knew this has been coming. It's a big roll. You don't lose sight of that.

Secondly, it's not just Medicare. The private insurance system is the same, has all the same problems. Its payment rates to providers are higher. It has the same issues with high utilization.

The high quality, lower cost, I think by and large those are unique places that are great, but they're not—whether you can replicate them over and over again, I don't know. I think the biggest problem we have in health care is that more spending probably does lead to higher quality and better care a good percentage of the time, and there's work that Jack Hadley and other colleagues of mine at the Urban Institute did that was published recently that has shown that. But the problem is that there's a limit to how much of this higher quality you can afford, that we as a nation can afford, and the problem is that if you lower spending, you could be cutting out some good things, and I think that's pretty much what we have to face. It's not a free lunch.

Senator BENNET. Well, actually, just on that point, Mr. Holahan, and I'd be interested on others' thoughts on this too, there's been some discussion around the Super Committee about whether or not they should approach Medicare with maybe an across-the-board cut of 2 percent. Should they do reform of some kind? Do people here—and I take it from what you just said that you think the 2 percent across-the-board cut would not be the best or most responsible idea.

Mr. HOLAHAN. I think a lot of the ideas that we all have mentioned and seem to agree on would get a big, big chunk of money, a long way towards that \$1.2 trillion.

Senator CORKER. \$1.5 trillion.

Mr. HOLAHAN. Sorry.

Mr. HOLTZ-EAKIN. \$4.0 trillion.

[Laughter.]

Senator BENNET. Whatever.

Senator CORKER. I agree, I agree. I couldn't agree more.

Senator BENNET. Sign me up for that.

Mr. ANTOS. A 2 percent cut in Medicare is nothing. That's what the sequester would do, and you can do that very easily with policies that don't make any difference whatsoever. You can lower the spending level a little bit.

By the way, relative to the baseline, is that really cutting spending? It's just slowing it down a little bit, but only one time. Most of the policies that MedPAC has proposed, that the President has proposed, those are just one-time reductions. They don't fundamentally change anything about the way the program operates, in particular the way the health sector operates. So your point I think is very well taken.

Senator BENNET. Thank you, Mr. Chairman, Senator Corker, for your time.

Senator CORKER. Very good.

Senator COLLINS.

Senator COLLINS. Thank you, Mr. Chairman. Doesn't that sound good, that "Mr. Chairman" part?

Senator CORKER. I don't think it sounds too good to Bennet.

[Laughter.]

Senator BENNET. You might be surprised.

[Laughter.]

Senator COLLINS. In all seriousness, thank you for assembling such a terrific panel of witnesses as we try to tackle this issue.

Before I start my questions, I just have to express complete agreement with Mr. Holtz-Eakin's comments on the CLASS Act. It is a Ponzi scheme that would make Madoff proud, and it should be repealed in its entirety. We shouldn't even be in the business of creating a new entitlement program that is funded in a way that it will be collecting premiums in the early years and thus appears to help the budget numbers, but then will explode in costs in the out years.

I want to follow up on the issue of reimbursements. My concern is that what will happen in an attempt to save Medicare is there will be harmful cuts in reimbursements to providers that will be either a tax on innovation or will curtail access to the extent that more and more physicians will decide not to accept Medicare patients.

I'm fascinated by statistics that two of you used which demonstrate that a small percentage of Medicare patients are responsible for the vast majority of Medicare costs. And if you look at that population, by and large they have one of three chronic conditions, of which diabetes is one. In fact, if memory serves me correctly, one out of four Medicare dollars is spent treating people who suffer from diabetes.

Rather than just make across-the-board arbitrary cuts in reimbursements, we need to rethink the entire reimbursement system, and diabetes care is a perfect example of that. Right now, if a patient has diabetes and it is poorly controlled, and that patient ends up losing his leg, we pay for everything. But we don't pay for a physician or a physician assistant or a nurse practitioner to call that man every week to check on his blood sugars and monitor his care in order to avoid the more expensive treatment. And that, to me, is what is wrong with our reimbursement system. It is not focused toward helping people who are consuming the most resources because of these four chronic diseases, helping them manage their care better and thus consume fewer resources.

So my question—and I apologize for the long intro—to each of you, and I'll start with you, Doug, is how could we restructure the reimbursement system toward that goal, and is that the approach we should be looking at rather than arbitrarily cutting all primary care physicians by a certain amount, or all specialists, or all hospitals?

Mr. HOLTZ-EAKIN. Well, I certainly agree that a strategy that involves just either flat across-the-board cuts or just cuts in reimbursement rates to providers is ultimately going to fail. That's been the history of the program. Going forward, we have to change its fundamental structure in order for it to serve the beneficiaries and survive financially. So reform is more important than savings at this point. You'll get the savings in the out years. We need to change the trajectory.

And then the second is there is a lot of evidence that, particularly with populations like the dual eligibles, that if their care is managed, we can have enormous savings. There are some Medicare demos that have actually shown this quite dramatically. The question is how to turn that from a research finding into an operational program for the Medicare population.

But I think if we made it a priority to comprehensively manage the care and pay capitated amounts for those patients, we would solve the budgetary exposure and we'd get the providers coordinating to get the care, because with a fixed amount of money they'd have to do it to get the savings to meet the budget constraint, and that we should do as fast as possible.

[The prepared statement of Senator Susan M. Collins appears in the Appendix on page 38.]

Senator COLLINS. Thank you.

Mr. Holahan.

Mr. HOLAHAN. Yes, I would—I'm only going to comment on the one thing, the high-cost beneficiaries. I really think that should be an extremely high priority. There's been a lot of work and talk about taking on care management for dual eligibles, but delegating that to states to run through Medicaid programs, most of the acute care dollars that dual eligibles use and other chronically ill people use are Medicare dollars, not Medicaid. So I don't think it's right to ask Medicaid programs to really manage the care of Medicare patients, and obviously that spending affects the Federal budget.

This really should be a Medicare responsibility, and I think that would be a major step forward, to make this a very, very high priority for Medicare instead of delegating it to states; not that some

states won't do a great job, but it will only be some states, and in other places it won't be much of anything.

Senator COLLINS. Thank you.

Mr. Antos.

Mr. ANTOS. Well, I think we're aiming too low if we're just aiming at dual eligibles. Of course, that's an important population, but there are other Medicare beneficiaries who are working their way towards there who haven't spent to the point where they're eligible for Medicaid. So we really need to focus on the Medicare problem, the high-cost Medicare problem. It includes the dual eligibles, but it includes more people. And if we make payments to make it attractive for organized health systems—you notice I didn't say fee-for-service Medicare—for organized health systems to take on these kinds of patients and to use real management techniques to coordinate the services of half-a-dozen doctors and numerous other kinds of institutional providers, we'll make a dent in this problem.

Senator COLLINS. Thank you. I know my time has expired. So is it okay? Okay. Thank you.

Ms. MacGuineas.

Ms. MACGUINEAS. Sure. Just quickly, then. You know, I'm actually struck by how we are kind of stuck in the same problem with health care that we are with the overall fiscal environment. Because we waited for too long to reform a lot of these systems, the pressure of limited resources is what's driving the discussion now, and in some ways we've lost the opportunity to really think about where to innovate, where to reform, where to spend more and where to spend less. And there's a good part of that, which is nothing like tighter resources focuses the mind, you know? We're going to have real spending caps in this area. But we also don't want to be short-sighted as we think about how to reform the system.

And I completely agree with your comments that the blunt tools of cutting reimbursement rates is not the thoughtful and right way to look at this. You really want to look at the delivery system in so many areas. One thing to keep in mind is that some of the most successful systems are those that maintain longer relationships with their patients, and the fact that Medicare, you have people once they're seniors and not before, so you have a kind of a truncated time period where the investments in their health care doesn't pay off to the same people who made them, leaves it in a very different system in terms of what the incentives are.

We do need to collect a lot more information on the performance of various changes and incentives to the system, but we need to also make sure that they're integrated in how we deliver systems and we pay more for what works. You can also look at cost sharing and have greater cost sharing in services and procedures that are not shown to work as well.

So we need to be a little bit more nuanced in how you work the financial incentives, I think, into rewarding in health care.

Senator COLLINS. Thank you.

Thank you, Mr. Chairman.

Senator CORKER. Thank you, Senator Collins.

Senator McCaskill.

Senator MCCASKILL. Thank you. Thank you, Senator Corker, and I wish there were more people down here, but I'm glad to be here

with all of you, and I think it's important, since we do have this time constraint that you referred to, that we try to focus. I know Senator Corker has tried to make this hearing about where we can find consensus, and I think there's a lot of places we can find consensus. And if we can just work hard in those places we can find consensus, then I think it might be surprising what we can get done. If we all stay over here, you know, that it's not about this or it's not about that and try to take political advantage of this fight, then I don't think we're going to move the ball, and that, candidly, is what usually happens. Everyone is busy taking political advantage of a situation, and guess what happens to the can? It gets kicked and kicked and kicked.

So I'm proud that—Senator Corker doesn't surprise me he does this, and my friend Senator Collins does it all the time, we try to figure out if there are ways that we can find consensus.

Let's talk about over-utilization. I had a group of docs that I was talking to during the health care debate, and they wanted to talk to me about the problems with—I don't remember if it was tort reform or what it was, and I said, well, let's just go around the table and tell me how often you use your machines. And there was a lot of shuffling and looking down, and we went around the table, and the least any of them were utilizing their machines was 92 percent. And, of course, the Medicare reimbursement is dependent on an assumption that they're only using them about 50 percent of the time. So it was pretty obvious to me that their business model depended on over-utilization, that, in fact, the profit they were making was over-utilization.

And I don't think we've really tackled that, and it seems to me that could be an area of consensus. Rather than dinging them on reimbursement, which is not the right way to go—I certainly agree with that—I am trying to get to this notion that my mother, who has three chronics and is 83, can have sometimes as many as 10 different blood works in 30 days, from four different specialists, all paid for by taxpayers, because it's all out-patient and it's all general revenue. It's not in a hospital.

So what are your ideas on how we get to this delivery system that has built a profit model on the altar of over-utilization?

Ms. MACGUINEAS. I think I'll return to something I'll probably return to a number of times, but back to cost sharing. So I think that all consumers need to have greater price sensitivity than they currently do in Medicare. And I would also add that there's a level of transparency that doesn't exist in the entire health care system. We need to really work at improving the transparency of the effectiveness, costs of the same things in different areas, and so that consumers have better access to the information of how well something works, how much it costs, and how much they would be involved in shouldering part of the burden.

And just a quick comment on the politicizing of Medicare. I just couldn't agree with you more, and I think we've seen this way too often across both parties sort of talking about the other wanting to change Medicare and demagoging on it, and if there's one thing that I hope comes out in this coming election, it's that we know we need to make major, major changes to Medicare, and everybody

should be looking for those that we can get most agreement on. So I agree with you.

Mr. ANTOS. You're absolutely right. Because of the fee-for-service payment system, the machines are profit centers. So the more you use it, the better. And if you raise the utilization assumption that Medicare uses to set the fees to, let's say, 92 percent, well, you've got 8 percent to go, you know? There may be eight hours in a day, but not for a machine. You can find ways to squeeze more money out of that.

Now, that said, a lot of those machines do some pretty wonderful things. So we want to be very careful——

Senator MCCASKILL. Right.

Mr. ANTOS [continuing]. Not to squeeze off the medical benefits. We just want to reduce the unnecessary use of services.

One of the things that the Medicare Payment Advisory Commission recommends which isn't going to work is for high utilizing radiologists, I forget exactly which imaging procedure, but whatever it is, it might be MRIs or something, that they would review these particular physicians, review each case and refuse to pay if they didn't see sufficient evidence that the patient really needed the fifth MRI.

Well, you know, you could do that, but how many services could be subject to that problem? The answer is all of them.

Mr. HOLAHAN. I guess I would answer it this way. I think the problematic incentives in fee-for-service medicine are obvious. Everybody knows that. In your case, in the case that you cited, I don't know whether that's over-utilization because I don't know what the information gain is from that 92 percent utilization rate.

I think what we really have, especially with the advanced imaging technologies that we have, is that we haven't brought down prices, the amount that we pay per test or per image, as these things have gotten cheaper and cheaper to do, and if they're used efficiently, the prices should have fallen, and they really haven't fallen——

Senator MCCASKILL. What do you attribute that to?

Mr. HOLAHAN. I just think we're dropping the ball. I don't know whether it's a MedPAC issue or what, but I think that public or private——

Senator MCCASKILL. Because you're right. It makes no sense.

Mr. HOLAHAN. I mean, my own experience with MRIs is that they ought to be used a lot because the information gained is so great, but they shouldn't cost anywhere near as much as they do. They just should be run around the clock, just as long as you're paying something closer to marginal cost. But, you know, I would stop there.

Mr. HOLTZ-EAKIN. I'd want to echo the remarks of Joe Antos in particular. I agree completely. I mean, remember, if we were paying an organized health group to manage someone's care, they wouldn't undertake an unnecessary test because it would be an additional cost they wouldn't want to bear. They'd keep track of the records so that they didn't have to replicate that in order to do due diligence on the quality of the care the person received, and they would negotiate for a marginal cost pricing and not pay full boat.

Fee-for-service medicine lets them get away with all those mistakes.

Senator McCASKILL. And more. Thank you.

Senator CORKER. Thank you, and thanks for being here.

Senator.

Senator JOHNSON. Thank you, Mr. Chairman.

Does anybody on the panel have any idea how much profit dollars in a \$2.6 trillion industry are really realized by pharmaceutical companies, insurance companies, providers? Anybody done a study? Mr. Eakin?

Mr. HOLTZ-EAKIN. I don't remember the number, but this came up in my past, and at one point if you confiscated all the profits of the pharmaceutical industry and the insurance industry, you would take care of less than two years of spending growth per person in the health care sector in the United States. So it is, relative to the \$2.6 trillion, not a big number.

Senator JOHNSON. I've been trying to get that number, and it may be under \$100 billion in a \$2,600 billion a year industry. So it isn't the profitability that drives cost.

I'm a manufacturer. I'm always looking for the root cause of the problem, and to me there are a number of root causes in terms of driving up costs in health care. The initial one I think goes back to 1945 under wage and price controls where we started separating the consumer of the product from the payment of the product. Until we reconnect that, until we re-induce the free market system which, by the way, guarantees, what, the lowest possible price and cost, the highest possible level of quality, the highest possible level of customer service, we're just not going to fix this problem. That's one root cause.

Another root cause is, as has been alluded to, 10 percent of individuals account for 60 percent, 20 percent represent about 77 percent of total costs. That's chronic care. It's also end-of-life issues.

We also have a technology problem. But as we also pointed out, technology has a real upside. If it weren't for cures, if it weren't for innovation, if we hadn't cured polio, what would our costs be?

So again, I just want people to address that, really what are the root causes. I mean, am I accurate in that? Is there another root cause in this equation?

Mr. ANTOS. I have a lot of sympathy for that viewpoint, as I hope my testimony made clear. I do want to say one thing as a word of caution to the committee, from my experience at CBO. Markets are phenomenal at driving prices down to cost, but they rarely drive them below. Price fixing by government health programs makes it possible for prices to be below cost. So sometimes when you move from a price-fixed program to a market program, it will cost the Federal budget money, which is going to be frustrating for those on the other side of this witness table, and you should remember that because it has come up in the past.

Senator JOHNSON. Okay. You led me exactly where I want to go. Currently, about the only reason that we're able to reduce cost to providers is because we have a huge amount of cost sharing, from the 50 percent that the government pays for to the 50 percent of the private sector, which is driving up private health care costs.

We've done work together in terms of the total under-estimation of what Obamacare is estimated to cost, because they only estimated 3.6 million people who would lose employer-provided care. When that number is driven to 50 percent, maybe 90 million people, possibly 180 million people, all those folks get dumped in the exchanges and government is paying for 100 percent, there will be nobody to share those costs with. What effect is that going to have in terms of our ability as a government to pay for this Medicare and Obamacare?

Mr. HOLTZ-EAKIN. Well, as you well know, you're leading the witness. I mean, I think it would be an unmanageable Federal budget cost if the estimates that I have done come to fruition. I mean, it will be two and three times the estimated budget costs every year for the insurance subsidies.

I'd also point out something else. Senator Corker mentioned the importance of doing tax reform and entitlement reform. It's all true. The order in which you do that matters. If you repeal the exclusion of employer-sponsored insurance from tax, then with certainty everybody ends up in the exchanges and you will have created an enormous budget cost. So this is not something you can do without thinking about how they interact, and this is a central part of a budgetary exposure. One subsidy is through the tax system, one is through the insurance exchanges, and this is really one subsidy competing with another, and if you toggle one, you'll get a response from the other.

Senator JOHNSON. The numbers we came up with, rather than an annual cost for Obamacare of \$93 billion, it's closer to almost a trillion dollars a year when everybody loses their health care and get dumped in the exchanges.

We talked a little bit about the SGR concern about what that's really going to cost. Anybody have an estimate of what that would really cost to fix?

Mr. HOLAHAN. I think CBO has estimated it to be about \$300 billion.

Senator JOHNSON. Per year?

Mr. HOLTZ-EAKIN. No. That's over 10 years.

Senator JOHNSON. Over 10 years? Okay.

Mr. HOLTZ-EAKIN. Remember that there's a year 11. There's a table of estimates in my written testimony, if you want to peruse dismal numbers.

Senator JOHNSON. Okay. Yes, I love scary numbers.

That's really about all I have. Thanks.

Senator CORKER. Thank you.

Senator Chambliss.

Senator CHAMBLISS. Maya, you talk in your testimony about three reform measures that have the potential to drive down costs, benders, savers, structural changes I believe is the way you put it. What I'm interested in is how we get Medicare beneficiaries to get more skin in the game. How do we get that individual who goes to the emergency room to think, "Gee, if I go next time, it's going to cost me \$25" or whatever it may be? I couldn't decide whether that might be low-hanging fruit in savers or whether that would be in your structural. But if you will, talk about that for a minute

and tell us your thoughts on how we get that more skin in the game attitude out there.

Ms. MACGUINEAS. So I would put that squarely in the benders category, which is where I think we should be focusing as much of our energy as possible right now in that it can save significant money in a 10-year window, but more importantly it would have compounding savings over time. And so I think the real key here, and we've all discussed it to some extent, is that if you have more price sensitivity than you have with the system right now where you pay for my health care and I pay for your health care and we all think we should have as much as possible, but if you have more price sensitivity and you have more information in a way that you can evaluate what is good for your own health and what is excessive cost, that skin in the game is critical to bending the curve over the long term.

I think we want to be careful. You want to make sure that while you're changing the way that the financing, the incentives and the financing of Medicare, that you do protect people against excessive cost. We know that one of the highest reasons for bankruptcy is health care costs, and you want to make sure that people are protected from catastrophic costs, and you want to make sure that people are protected from paying a greater share of their income than they can.

So it's some combination of means testing, but not to the extent where the system unravels for the parts that are voluntary, and greater cost sharing. But nobody should feel that going to the doctor is just sort of a pastime. It needs to be something that you evaluate like you do with all other purchases, whether it's worth it, and I think that's the most important reform we could be looking at right now.

Senator CHAMBLISS. Would you agree that that is the mindset right now on folks who have been used to the government taking care of their health care, whether it's through Medicaid and graduating into Medicare, that there is that feeling, consciously or subconsciously, that I'm entitled to this, the government is going to take care of me, and until we change that curve, we're not going to bend that curve, the Medicare cost curve down?

Ms. MACGUINEAS. I think certainly there are three things that contribute to it: one, that you've paid into Medicare, though as we heard in the beginning, you haven't paid nearly enough into Medicare to cover all that you'll be receiving out of your lifetime, but you feel that you've paid into it; second, that you don't see anything close to the real cost when you go to the doctor; and third, that it's health care, and so everybody can work themselves up into a tizzy that this has got to be vastly important, I have to go to this doctor just in case this is a serious thing, and you lose the ability to evaluate whether it's worth the cost.

But those three factors all contribute to our over-utilization of health care, and I think price sensitivity and better information are the keys to helping bring that back down to closer to realistic levels for demand.

Senator CHAMBLISS. Let me address this to the whole panel. My thought on SGR is that if we don't fix this thing for at least 10 years, we're kidding ourselves. We know we're going to come back

and we're going to stick that band-aid on it every year. There's no policymaker that could go home and look his docs in the eye without doing that. But if we do that, it's going to be more expensive on us over that 10-year period than if we go ahead and bite the bullet and do it for 10 years.

And the second part of that, I am extremely concerned that if we don't come up with a long-term solution to SGR, that we're going to lose docs like we've never seen before. Now rarely does a doc who is under 40 years of age—excuse me—yeah, under 40 years of age come into my office and he accepts Medicare patients. They're pretty smart about going into a field where they don't have to take them, or into a region where they don't have to take them to make a good living.

So what I want you to address is what do we need to do about SGR? We've got to pay for it somehow. But am I wrong in thinking that if we don't fix it for at least a 10-year period, that we are missing an opportunity and that in the long run this is going to cost huge bucks?

Mr. ANTOS. I certainly agree with that. Of course, 10 years is forever. As long as you've replaced it with something. You have to find some method of limiting unnecessary growth in health spending in Medicare generally. Now, if you want a short-term fix, MedPAC has plenty of ideas. You spread the pain around. Instead of taking a 30 percent cut in January for all physicians, you take a much smaller cut in specialists. You freeze specialists and primary care. That's not an unreasonable thing to do. The rest of the health sector has to kick in as well.

However, that doesn't fundamentally solve the problem. You still have a fee-for-service Medicare program where the reason why patients go from doctor to doctor is they don't have a sensible place to go otherwise. We've got to fix that problem, too.

Mr. HOLAHAN. I would say certainly you have to fix it. It's ridiculous sort of to do this every year, and a long-term fix that would be a freeze or a small rate of increase in fees just makes a lot of sense.

One thing I would say is even though we come back and we don't let fees fall, and so prices aren't going up, it is important to remember that spending on physician services is going up much faster, 7 or 8 percent a year, because the volume of services are going up. So that means that the incomes that physicians are receiving really are not falling. I mean, that's just not right. But nonetheless, and it's not just because of the reaction to the low fees but because of a lot of other factors, new technologies, new procedures that come along.

So I would fix it, but it's not because docs are really hurting because of the current policy.

Mr. HOLTZ-EAKIN. If I could, in my testimony we put in some of the survey evidence that showed the response of physicians the last time Congress didn't pass a patch in a timely fashion, and there's a whole array of things from contemplating not seeing new Medicare patients to actually never seeing them ever again, and I think that's a tribute to the concern you should have about not fixing it. You have to fix it or beneficiaries are going to suffer, and it is an

artifact of the current law baseline fiction to pretend that this is costing you something.

You're going to spend the money because you're not going to let beneficiaries not have access to doctors. As a Congress, you can't have that happen. You never have. You've always spent the money. It's always ended up in the actual Federal deficit. It will end up in the actual Federal deficit in the future. So acknowledge the reality, fix it, and then start realizing that this is a 5 percent reduction every year in overall Medicare spending, and that's something you're going to need to get to begin with.

So, you know, get this off the books, stop messing around with that corner of Medicare, and then fix the program.

Senator CHAMBLISS. Thank you.

Senator CORKER. Thank you, and thanks for being here.

Senator KIRK.

Senator KIRK. Mr. Chairman, Madam Chairwoman, I want to honor my promise on Medicare to my mom, to defend the program, and I think we need to advance our reforms that can be enacted, especially in a carefully balanced Congress, because in the end I think we're judged by did you affect the process or not.

When you look at reforms that we can make, I think we can build some consensus behind some, and one thing I want to look at, behind me you have the old Medicare card, which is what every senior has. Senator Corker and I, especially Senator Wyden, we've joined together to upgrade the Medicare card.

This is a military ID. The United States has issued 10 million of these at \$8 each, and they tell me—actually 20 million—and they tell me that not a single one yet has been counterfeited. But it has a number of upgrades, both front and back, that I think would really help seniors out.

Notice on the Medicare card, you have the Social Security number printed straight on the front of the card, which is an invitation for ID theft. And so Senator Corker, I and Senator Wyden, we put together an effort to have the new card—this is what it looks like—where everything is held in a chip and it's modeled after the established CAC card, common access card technology, that already was pioneered in DOD and now throughout the intelligence community, et cetera.

We estimate that—Medicare is over a \$500 billion program. The Department of Justice says we have about \$60 billion in waste, fraud and abuse now in the program, which I think is three trips to Mars per year wasted out of the program.

Here's my question, though. Doug, I love your testimony, but I'll blame you personally because of your old employer, CBO, something that we need to fix, and I want your advice on it. And for John and Maya, thank you because in your testimony you said program integrity improvements are key, and here's the question. Why can't we move to an upgraded card so that we actually know the recipient is receiving service at the point of service with a PIN number?

This is something that now, as 9,000 baby boomers qualify for Medicare each year, everybody understands this technology.

And B, why is it that CBO will not score upgrades in program integrity that we know will reduce waste, fraud and abuse, totaling

more money than most United Nations members' gross domestic products in a year?

Mr. HOLTZ-EAKIN. So on the program integrity improvements, let me do it with the IRS as an example, to take it out of the subject of the hearing, and then we'll come back to your card. The scoring rules are set up so that you cannot simply appropriate more money to the IRS and assume that you will get back \$1.20 in tax revenues for every dollar of appropriated funds. That's to remove any pretense that the appropriators could create a money pump for themselves and simply spend it. So that was a conscious decision made by the House, the Senate majority, the majority of budget committees, OMB—

Senator KIRK. Which is understandable.

Mr. HOLTZ-EAKIN. So that's a scoring rule to which CBO adheres. Now, there are exceptions to that rule, and the exceptions are when the money is accompanied with a new tool that would genuinely improve the performance of the program.

And so during my tenure at CBO, an example that came up was the IRS was allowed to hire private collection agencies and pay them 25 percent of whatever they collected on taxes that were outstanding, and I made the determination that this economic incentive, getting 25 cents on the dollar, constituted a new tool that a conventional IRS agent didn't have and that we should reward those outlays with some IRS savings. It was not a uniformly popular decision, but you will be in that area, quite frankly a budgetary gray area, with the card. To what extent is that a new tool which changes the ability to monitor and operate the program? That's the issue.

Senator KIRK. Just before I go to John and Maya, I just want to say that we have now a number of Democrats and Republicans in the House that have backed this effort, and it makes sense. The legislation is to roll it out, 50,000 providers, 1.5 million recipients in five different areas. And I think getting the Social Security number off the card, A; B, picture magnetic stripe and chip; and C, PIN number punched in at point of delivery so that that person with that card received that service at that time.

But for Maya and John, you mentioned this directly in your testimony, program integrity improvements.

Ms. MACGUINEAS. Thank you, Senator. I had a chance to look at your proposal, and I think it's a very solid idea in that it would both help with waste and fraud and also confusion. So it would clarify the system for people in a lot of ways.

And one of the points I tried to make in my testimony is, again, I know we're making all these decisions because of limited resources, and I worry about responsible budgets, and so the bottom line is what matters. But there are also important policy changes that we have to make, and even when they don't score well, and even though I'm the biggest fan of CBO, I think what they do is incredibly useful, you don't have to let that be the bible of when you adopt policies or when you don't.

So I know that we're trying to make reforms to save money and improve the health care system, but there are plenty of ideas that aren't going to score tremendously well which we should proceed with, and we would think that this is one of them.

Senator KIRK. John.

Mr. HOLAHAN. This isn't an area I feel I have a lot of expertise in. It sure looks really like a great idea to me, just off the top of my head.

Senator KIRK. Thank you.

Thank you, Mr. Chairman.

Senator CORKER. Thank you, and thanks for your hard work.

I might ask some questions now, if that's all right.

Senator McCASKILL. Oh, sure. I forgot you didn't.

Senator CORKER. No, I didn't. I'm so glad so many people are here and we have such outstanding witnesses, I wanted to wait, but let me ask a question.

I think all of us believe in markets on both sides of the aisle, and I think there's—I mean, I certainly agree that if people who use services pay for a portion of those services, utilization is going to go down, and I agree that's low-hanging fruit from the standpoint of driving savings.

How do we rectify that or balance that off against the fact that there are some people who genetically just end up having poorer health for reasons that are beyond their control? So even though, yes, in a normal market system people can choose services based on high quality, some people are left with the fact that they have to have the health care because of their own situation. And each of you do not have to respond to all of these questions, but those who feel most compelled, if you would, how do you respond?

Mr. HOLTZ-EAKIN. I would respond in two ways. Number one, even those who have a chronic condition beyond their control still have an interest in having the lowest-cost provider give them the health services that they require with sufficient quality incentives. So the fact that you are born with that doesn't relieve the system of an obligation to deliver services at low cost.

The piece that is different is the insurance piece, because that person doesn't fit in a catastrophic acute care insurance model where events are unpredictable but they happen only occasionally to a person and they're easily smoothed out. They are predictably high cost, and that's not insurable by that conventional model, and we need to manage their care, and in the end, given the nature of the condition, we'll probably have to assist them in affording it. I mean, that's a reality that a society will face.

Senator CORKER. Anybody else feel compelled to answer?

Mr. HOLAHAN. I would just—first of all, there is a fair amount of cost sharing in Medicare. It's not structured very well, and a lot of us here have said that should be reformed, particularly with an out-of-pocket cap. Because of the lack of an out-of-pocket cap, people then tend to over-insure through buying Medigap policies. So the Bowles-Simpson and others have recommended that. I think most of the people here have endorsed that. That would, I think, go a long way to getting you where you want.

The thing that in a lot of these proposals isn't there is whether this ought to be related to—out-of-pocket caps ought to be related to income. I think they would. Therefore, your low-income, chronically ill people would be protected more than they would if it was a straight, say, \$5,000 to \$7,000 cap.

Senator CORKER. So let's actually move to that. You know, I think a lot of people, one of the things I think there is consensus on, or at least a degree of consensus, is that people like myself and Ron and Claire that have done well in life——

Senator MCCASKILL. Or married well.

Senator CORKER [continuing]. Or married well, should have to pay a lot more, and maybe we don't even receive Medicare benefits at all if we're in certain categories. I know Ron and I probably shouldn't even receive them.

There are groups, though, in our country that would say, well, no, that really demeans the integrity of the program. It turns Medicare into a welfare program, and these are folks that actually are there, you would think, to protect the program.

I wonder if you might have any response to wealthier folks having diminished or no Medicare benefits. I know that doesn't solve the problem, by the way. I know that's only, like all these other things, a part of the solution. But means testing obviously for this to work is going to have to go way down the financial spectrum, not just upper income. But respond, if you would.

Mr. HOLTZ-EAKIN. The systems are already progressive by their nature in that Social Security, Medicare, Medicaid, we attempt to provide more benefits to people who have lower incomes, and they don't pay commensurately. So this is simply extending the degree to which these systems, which are already progressive, become more progressive, and I have no objection to doing that because, in the end, if we were to stop providing benefits to some high-income individuals and the system as a whole was not universal, which is the concern these groups often express, I think that perceived infringement of fairness in the moment is dominated by really rectifying the unfairness to the next generation of not fixing these programs and leaving to them both broken social safety nets and a mountain of debt.

So fairness has lots of dimensions, and the one we are most likely to be unfair to is the next generation at the moment, and I think this fight over universality pales in comparison to that.

Senator CORKER. A differing point of view?

Mr. ANTOS. Well, I don't have a different point of view, but certainly a sensible thing would be to recognize that we already do it. Not only do we do it in the sense that the benefits that are received go more towards people who have higher cost conditions over their lives, but also obviously we have income-related premiums in Part B and Part D. It makes no sense to have this subdivision of A, B and D. From a financial standpoint, it makes no sense. It's not the kind of insurance anybody else has until they turn 65. So why can't we have a single, unified premium? Why can't it be highly progressive? The Heritage Foundation supports it. People on the left support it. It seems like a pretty reasonable principle when we have to face fiscal reality.

Ms. MACGUINEAS. I'd love to jump in just because I feel so strongly that means testing is really the structural reform we need to be most broadly be considering as we look at this overall budgetary situation, and it goes from unifying all of these. But the co-payment, the premium, the caps, I think the more that we can link

them to income, the better it works for price sensitivity and fairness.

And I have to admit that I've always been dismayed by the argument that means testing these programs turns them into welfare programs where they then won't have the same broad-based political support, because what you see right now is that these very programs are squeezing out all the programs that are focused on a safety net and focused on programs for the poor, and you also see that some of the fastest growing programs in our budget recently have been the EITC and Medicaid, which are directed towards the poor. And so it seems to undermine the argument that there won't be political support if something is more targeted.

So it seems to me that in an era of limited resources, not only is it unfair to the next generation to spend all this money on entitlements, particularly when people don't need it, but it's unfair to the rest of the budget. Whether you want to cut taxes or raise spending on other things, if it's being squeezed out because we're spending money on entitlements for people who don't need it, that's clearly not the best use of the limited dollars.

Senator CORKER. I'm going to yield to the other senator since my time is up, but I would like to ask you to do this. You all, each of you meet with differing groups, Republicans, Democrats, Independents. If you would do this for me, I'd appreciate it, and that is to send me—it doesn't have to be sophisticated. It can be bullet form. Send me the things that you think people on both sides of the aisle would readily adopt based on the multiple conversations that you've had with people on both sides of the aisle so that those could be compiled without attribution to you, unless I guess they would be with attribution to you since they'd be in the public record. But if you could send those to us so we could forward those on to the committee as things that we know have general support on both sides of the aisle so we can actually move this ball forward.

And with that, I'll turn it over to Senator McCaskill.

Senator MCCASKILL. Thank you. Is it Ms. MacGuineas? Is that how you say it? MacGuineas. Ms. MacGuineas, I don't think you need to worry about the Senate seeing a CBO director as the bible. We have a great deal of trouble—

[Laughter.]

Senator MCCASKILL [continuing]. Paying much attention to the CBO around here. In fact, we only like the CBO when it agrees with us. And if it doesn't agree with our position, then the CBO doesn't work anymore. If it agrees with the other side's position, then they are dumb, and if they agree with us, they're brilliant. So poor CBO is one of the very favorite games of ping-pong around this place.

You know, when we talk about free market, I think all of us are agreed that we need to get more skin in the game. But if you look at a free market, what makes a free market work are better incentives, incentives are what makes a free market work, an incentive for profit, an incentive for quality, an incentive for value, and good information. We know where every cup holder is in a car we buy. I had my knee replaced, and I was a United States Senator. It took me six months to get information as to what it cost, and I got three different numbers, one from the doctor, one from the hospital, one

from the insurance company, and none of them matched. So there is not good information.

The other place the free market analogy falls apart is that I can choose whether I buy a new car. If my child is dying, or if my mother has had a traumatic injury, I've got no choice but to buy health care. And what really handcuffs my ability to make good decisions in health care is that I don't have good information, whether I'm taking her to the right place or the wrong place; the right doctor, or the wrong doctor.

And so I would like to know, to the extent that government should be involved here, and I understand there should be a limited role, how should we be forcing more good information on the consumer? Because Americans are great consumers if we can get the information, but most Americans don't think to ask what it's going to cost because they see it as free because it's a benefit they've received; and most people that are selling health care are certainly not incentivized to tell you what it costs because, frankly, it could change between the time they did the procedure and the time that they actually get paid for it, depending on what the relationship is between the insurance company and the provider at the time.

Ms. MACGUINEAS. So I think obviously health care is one of the most complicated fields there is because it will never be a total free market because insurance complicates it so much. And so it's finding the right balance between those two, and I completely agree with you that more information, better information, more transparency is a key to helping this get the best of how markets work while also having the protections that insurance offers, and I think that means publicizing—I mean, it's almost gimmicky, but as much as possible getting to things that look like price lists.

I think we all have those stories of once asking your doctor how much something was going to cost and having that blank stare that he or she had no idea, and we need to be moving in the direction where you actually have a sense of the cost, publishing the hospital information, a lot of things that people are concerned about because of secrecy and privacy, but I don't think that works at all in what we're trying to accomplish here.

And I also know that the Business Roundtable is working on coming up with a lot of specific ideas of how to develop improved transparency and information in the health care field which I think should be taken very seriously.

Mr. ANTOS. CMS produces all sorts of quality information on providers. Nobody looks at it except people like us. Why is that? It's because most people get their information from their doctor. So another part of this—I completely agree with Maya. But in terms of really getting good advice, we're going to get it from our doctor. And so we really have to focus on how physicians practice medicine, because they are, in fact, the quarterbacks for our health care. You get a bad quarterback, you're going to get a bad result, and we're going to spend a lot of money.

Senator MCCASKILL. Integrity in the program. One of the problems we have, and I've encountered this firsthand, is a dizzying array of contractors as it relates to integrity. Isn't there some value in us bringing some of the functions of integrity in-house?

Shouldn't we have the core competency of integrity within the house of CMS and Medicare, as opposed to it's awfully hard to hold anyone accountable for the results as it relates to integrity because you can't find who is responsible because generally it's a maze of contractors? Any input on that subject matter from you all?

Mr. HOLTZ-EAKIN. I don't think you can draw a firm line on that front. I mean, the Federal Government as a whole has gone through many different iterations of in-house production versus contracting out, and I think the lesson of that is one that says that it depends on the quality of the contract that you write with the contractor, the ability to enforce the deliverables, and in the end, especially for Medicare, the biggest problem is the fact that we are operating in a pay and then chase framework where we've said we have to pay people, and then we'll figure out later if it was fraudulent or inappropriate, and then we'll go get the money back. If you don't change that incentive, it isn't going to matter where you put it. That's the big problem.

Mr. ANTOS. If you swear in every private sector employee of all those contractors today, does anything change? No, unfortunately not. So I don't—

Senator MCCASKILL. Well, maybe we'd know how many of them there were, because you'd be amazed how many parts of government can't even tell us how many contractors they have working for them.

Mr. ANTOS [continuing]. Well, that's completely true, and I'm sure there's a problem in Medicare as well. But my point is that you have to have a good focus on what your goal is, and it's not at all clear that we know what our goal is in this area. We talk about reducing fraud and abuse, but bills get recycled, and many of those bills are actually appropriate bills, but they get coded wrong. So it's really hard to know how to focus in on this when, in fact, if you eliminated fraud and abuse altogether, you'd solve part of the problem but you'd still be on the same cost curve because it's utilization that matters.

Senator MCCASKILL. Right, right.

Thank you, Mr. Chairman.

Senator CORKER. Thank you.

Senator JOHNSON.

Senator JOHNSON. I'll just turn myself into a witness here. I'll answer your question. The free market would—

Senator MCCASKILL. Do I get to follow up with more questions?

Senator JOHNSON. Sure.

[Laughter.]

The free market itself would force the information. Again, when you reconnect the payment of the product with the consumption of the product, individuals, when they're paying for something—take a look at the Internet. Take a look at how much people research a big-screen TV. Now again, in medicine it's more difficult. It would be very difficult to operate as a pure free market system. But you're not going to have a top-down approach where you say you're going to force the information on people. You need a bottom-up approach by utilizing the free market, reconnecting the payment of the product with the consumption of the product, and, trust me,

consumers will demand the information so they can make wiser consumer choices.

That's all I've got.

Senator CORKER. Thank you.

Let me—assuming the health care bill continues as is, I know there's a lot of dispute, and who knows what happens in the future, but let's just say that it ends up being implemented as it now is. Exchanges are being created under the health care bill that passed. The exchanges themselves, forget everything else that goes with it, but could they possibly be turned into a useful tool as it relates to delivering Medicare itself?

Mr. ANTOS. Yeah. I mean, certainly the concept is very sound. Economists of all stripes have argued for a long time that if you give people choices in the market, give them information about what they're buying, let them know what the price is, ideally have them pay part of the price, that they're liable to make a pretty good decision because they stand to gain if they make a good decision, they stand to lose otherwise.

You look at the Federal Employees Health Benefits Program. I think that's an example of an exchange that works. It's a lightly regulated exchange. I think that's one of the keys. In the Medicare program we could be doing that now, but we're not. We're got the Medicare Advantage program. It's completely separate from traditional Medicare. It does not compete on an even basis with traditional Medicare. The changes that were made in the Affordable Care Act didn't actually correct that. It just adjusted the mistaken payment mechanism.

So as a general concept, I think it's a very sound concept. That said, there are lots of arguments about how you want to run this thing. If you're going to have an exchange, then you have to decide how you want the subsidies to go. Can you have traditional Medicare operate with an uncapped subsidy? It depends on the other rules that you put in the system.

Ms. MACGUINEAS. Yeah, I would say that the exchanges are something that I'm a proponent of. I think that they are a great step forward in how they're going to allow us to make other needed reforms. The subsidies I have grave concerns about, and the costs that go along with those. But the exchanges add many values.

I think one of them is that we can now have a serious discussion that we couldn't have before about raising the retirement age for Medicare, because before there wasn't an alternative for people when they weren't going to be able to get health care. Now there is an alternative, and raising that is going to shift costs, perhaps more than it's going to save costs, but it could be a very large improvement to the Medicare system, and it was something that was on the table in the bipartisan discussion over the summer.

Secondly, I think it opens the door for competitive bidding, so thinking about how, as Joe was just saying, we can run some systems parallel to Medicare, reform Medicare so it's on a more even, level playing field, and think about how to use those exchanges to bring out the pricing mechanisms and a little bit more competition parallel to Medicare.

Senator CORKER. But let me just follow up. You really couldn't do that if Medicare is fee-for-service, right? I mean you'd have to end up with a premium support-type effort; is that correct?

Ms. MACGUINEAS. What you'd have to do—that's right—is cap the costs that were allowed for Medicare so that it wasn't open-ended. And as I said in my opening remarks, I really think that's one of the major points of where we're headed. We're going to have to pick which architectural reforms we embrace, but we're going to have to find ways to set a budget for Medicare and Federal spending on health care, and then find which of the mechanisms that we decide to pursue are the most efficient and effective in staying within that budget. So, yes, I don't believe Medicare is going to be able to be open-ended, and I don't think it should be.

Senator CORKER. Doug.

Mr. HOLTZ-EAKIN. I want to agree with all that and I want to emphasize an aspect of that, which is that well run exchanges could provide for seamless transitions that allow provider networks to remain intact. So, for example, not the subject of this hearing, but there are going to be a lot of people who are in Medicaid who will then bounce up to be eligible for insurance subsidies, and then they will bounce back down and be back in Medicaid. Those transitions are going to happen a lot. If the exchanges are well designed and people are appropriately enrolled, we could get them in the same provider network instead of saying, well, right now you're in Medicaid, you go to that hospital, now you're in the insurance subsidy, you go to that hospital. They'll get terrible care if that's how it works out. So that's a key design issue.

In the same way, you could have someone transitioning from employer-sponsored insurance to an employer-paid retiree plan, which could be commingled with Medicare and they could stay with the same docs, they could stay with the same providers, and they'd get better care. So how those are done is at the centerpiece of a lot of the future of American medicine.

Ms. MACGUINEAS. And on that, the continuity of care is also going to improve the investments, the incentives for up-front savings and the way that you're going to treat patients if they can stay in the same care systems for longer.

Senator CORKER. How would you feel about making Medicare claims available to the public? You would de-identify who the person was. But how would that affect the whole way of looking at the integrity of the program and just claims and costs and all of that?

Mr. HOLTZ-EAKIN. I think there are two things. I mean, the first is that when I was on MedPAC and we simply went through and looked at episodes of care, urology care, whatever it might have been, congestive heart failure, if you simply displayed the wide variation in cost of an episode of care for the same risk-adjusted patient, participants were shocked. And so displaying this would actually, I think in many ways, have a big impact on the way they practice medicine, because they just have no idea that they're so far out of line with norms.

The second thing is that privacy advocates always get nervous about this, but to my mind if the taxpayers are paying for it, there's a higher threshold and they have a right to see what they're

getting for their money. And so I have been much more sympathetic to this notion than a lot of people.

Senator CORKER. What type of folks oppose it?

Mr. HOLTZ-EAKIN. Usually doctors.

Mr. HOLAHAN. Well, there is already a Medicare beneficiary survey that links to claims data, and the advantage of using the survey and linking to claims data is you know an awful lot more about the people. So we do have access to that kind of data for a sample.

You know, 100 percent of Medicare claims is just an enormous undertaking as an analyst and a researcher. So we may be pretty close to having what we need. I don't know that there's enough money put into analyzing the data that is available to us, nowhere near enough.

Mr. ANTOS. I would just add that one of the issues is if you keep it in-house, then you don't get different opinions about what constitutes quality care. I think this is one of the big disadvantages that Medicare now provides us. They carefully limit who has access to the detailed information that is absolutely essential to evaluate provider performance. There is a lawsuit now working its way through the courts to try to get Medicare to loosen its grip in an appropriate and fair and reasonable way. But the fact is that different analysts will have different weighting systems and different views about how you should evaluate provider performance.

Senator CORKER. I want to ask one last question. I don't know if Senator Johnson has any more. I do want to reiterate I think it would be a tremendous service if each of you would outline what you think generally uptake would be on both sides of the aisle on various—or what you think both sides of the aisle would actually have a degree of, enough common ground to actually maybe make something happen. I think that would be a huge, huge contribution to us.

You've all talked, we've all talked about SGR, and every year when SGR, when the allocation that we give physicians that year is about to run out, the physicians across our country call and are upset, and then we extend it another year, as we should. But how do you actually—when we talk about \$300 billion, that's the money side of SGR. I didn't really hear how you make SGR work. I mean, it's kind of a Soviet Union mentality, and that is you give a bucket of money to physicians, and the more that it's utilized, the less they each get. It's kind of the opposite of the way things normally have worked in our country. So how do you actually reform it so that it works?

Mr. HOLTZ-EAKIN. You don't. I mean, you don't in the end. Your observation is correct. I mean, it's a near-term budgetary issue, but it is not a future for Medicare, and you need to go to something else, and my preference would be something that looks like premium support.

Senator CORKER. So that's, in essence, a privatized system, just like the health care delivery we have for most individuals that are below 65. Is that what you're saying?

Mr. HOLTZ-EAKIN. It looks a lot like FEHBP, the Federal employees plan, and that's been a very successful and sensible approach.

Mr. ANTOS. The other thing is we've created this wall around physician services that makes no sense clinically or financially.

We've got to integrate it. That's one of the big problems with traditional Medicare, nothing is integrated. So fixing this would just shore up a system that is doing a disservice to patients.

Ms. MACGUINEAS. I—

Mr. HOLAHAN. I don't—I'm sorry.

Ms. MACGUINEAS. Please go ahead.

Mr. HOLAHAN. I was going to say, I don't think you can really fix it either, but I'm not sure where I would go with that. I mean, I think you need to give modest increases to physicians every year, but I think you need to realize that Medicare spending, if you look at Part B spending, it is not going up at a zero rate, so that is really not the problem. But to continually go back and have to talk about 29 percent increases in fees in a particular year just gets to be a bit crazy.

In terms of premium support, let me just say I don't think it will work. I don't think there's evidence that private plans really manage care and pay less and are more efficient than traditional Medicare. I think the one thing that we haven't focused on here today is what I think is one of the real drivers in health care costs, and becoming more and more a big one, and that is the concentration on the supply side, the consolidation among hospitals, the purchase of physician practices by hospitals, and the great difficulty insurers have in negotiating rates with them.

It's driving up costs on the private side. Medicare is a bit protected because it sets rates. Most providers accept those rates. And I think if we're—I just don't think we can expect to turn this over to the private insurance system and get a good outcome. I think if you have a Medicare exchange in which Medicare is one of the competitors, and if Medicare is more expensive than, say, a benchmark plan, people should have to pay more for it. I'm fine with that. But I just don't think if this played out that you would see Medicare go away as a payer, a major payer.

Mr. ANTOS. Why don't we give competition a fair test? The problem is that when people talk about premium support, they usually talk about something that actually couldn't work. They are notions rather than policies. And one of the big debates is how much should the subsidy rise by. So everybody is consumed with should it be GDP plus 1, should it be CPI, should it be something else. Well, it should be something else. It shouldn't be set that way. It should be—it should come from the Medicare program because that's where the costs are coming from.

So if we had full competition, including traditional Medicare except improved traditional Medicare so it can actually survive, you have full competition among the plans and you set the winning payment amount for the plans at the market clearing price, and then you give everybody a fixed subsidy, some percentage of the winning bid, then you can be certain that people will be able to buy a plan. There will be at least one plan in every area where they pay no more than the standard Part B premium, and the winning bid will sometimes be traditional Medicare. There are plenty of places in this country, plenty of markets where, in fact, there is this concentration or there simply is only one hospital in the area, rural areas. The fact is you can't really have effective competition

where you don't have—in the insurance market if you don't have effective competition among providers.

So you can split the difference. You don't have to go in an extreme way, and you can find out what works.

Mr. HOLAHAN. I think that's—he said it in a terrific way. I think one could debate how many markets are so concentrated or so small that it's never going to work, versus finding those markets where it would. And if you want to let Medicare go and compete with private insurers, sure, let's do it. But it's not going to be a major game changer, in my view.

Ms. MACGUINEAS. I wanted to make one comment on the SGR point that you brought up, but slightly different than how to fix it because I think your premise was right, that going back to the same top-down model is still going to lead to imperfect results.

But one thing that was really interesting in the Bowles-Simpson Commission about the SGR, the need to fix it, which everybody understands, was there is so much tension around the health care issue. We all know that it's very hard to move forward on this, and I really think your idea of let's find all the pieces that most people can agree with and try to move there is the right approach.

One of the things on the Bowles-Simpson Commission that they were able to do is I think some folks came in and said we don't even want to talk about health care unless we're going to repeal the President's health care reform, and folks on the other side of the aisle came and said if you even talk about repeal, we're not having this discussion. And the one place they were able to find a discussion they could have was, well, at least we need to offset the cost of SGR. We know we need to fix it, and so there's \$300 billion in savings we have to find.

And I think for this whole “go big” model, you need more than \$300 billion in savings, but I think that's a really good start. Let's say we're going to find a way to permanently fix that and change that, and use as many of these cost savers to offset that.

I could get dragged into the premium support discussion, and I think it's the heart of all this. I don't think we're going to get it resolved in the next couple of months, but I think again in order to create a system that can stay within a budget, we're going to have to have a couple of parallel systems, and I think that what Joe has laid out and what the Domenici-Rivlin plan put out there is really the key to this, which is if we have a couple of parallel tracks to bring more competition in it, you keep a reformed Medicare system there, you use competitive bidding to make sure that people will have access to this. I think that's a real model for looking forward, and we shouldn't get caught up on whether the growth rate of premium support is too high or too low because that's just one of the levers we can move around. It's the structural or architectural reform that we should really consider.

Senator CORKER. Senator, do you want to ask any other questions?

Senator JOHNSON. First of all, I just want to thank all the witnesses for your thoughtful testimony. I certainly learned a lot. I hope people watching did as well.

I want to thank you for driving this hearing. It's very good.

I also want to say it's an extremely good idea to look for those areas of agreement, so I hope you submit those to Senator Corker.

Without opening up a whole new can of worms, just a real quick question. We talked about the 10 percent using up 60 percent of the cost, and 20 percent using 77 percent.

What drives end-of-life care? I mean, do you know a dollar figure or a percent spent on the last six months of life, last three months of life? I've read that in the past. I don't have a current number, though. Then I'll close. Thanks.

Mr. HOLTZ-EAKIN. I don't know the number off the top of my head.

Mr. ANTOS. I vaguely remember a study by my former colleague, Steve Jencks, or Jim Lubitz, and it's not as high as you would think. We spend a lot of money getting to that last year. I mean, one of the interesting things about health care is that if you get old enough, like my mother who is 95, and you get sick, the medical system isn't going to touch you. But if you're in your 70s, we're going to pull out all the stops.

Senator CORKER. Well, listen, I think all of us in the Senate stay generally frustrated about the lack of progress in solving problems, but I think each of us wake up each day also with a tremendous sense of privilege that we have the opportunity to have really intelligent and learned folks like you come in and testify, and we thank you for that and we look forward to the materials you're going to send forth.

I hope there are other forums where the four of you are doing exactly this for other senators and other committees, but thank you for doing this today. Thank you.

[Whereupon, at 3:53 p.m., the hearing was adjourned.]

APPENDIX

STATEMENT OF SENATOR SUSAN M. COLLINS
SPECIAL COMMITTEE ON AGING
“A TIME FOR SOLUTIONS: FINDING CONSENSUS IN
THE MEDICARE REFORM DEBATE”
OCTOBER 12, 2011

MR. CHAIRMAN AND RANKING MEMBER CORKER, thank you for holding this hearing to see if we can forge a consensus around some recommendations that could be made to the Joint Select Committee on Deficit Reduction.

Medicare is a critically important program that provides essential health coverage for millions of our nation's seniors and disabled citizens. It is therefore imperative that we proceed cautiously, particularly in light of the fact that Medicare has already been cut by half a trillion dollars to finance a new entitlement program under the President's health care plan, which I opposed.

It is, however, time for our country to have a serious debate about how to secure the future of Medicare, particularly in light of the 2011 Medicare Trustees report projecting that the Part A trust fund will be exhausted in 2024, five years earlier than predicted in last year's report.

I have opposed past efforts to restructure Medicare in a way that could be harmful to the 48 million American seniors and disabled individuals who rely on the program. I believe, however, that there are reforms that could be made without jeopardizing access to affordable, quality health care for our nation's seniors.

I am also mindful of the mounting deficits and towering national debt our country has accumulated and its impact on our seniors and indeed all Americans. These inescapable facts are among the biggest challenges this country faces. The importance of Medicare and the magnitude of the fiscal challenges we face as a nation underscore how important it is that we reach a bipartisan consensus on a way forward.

Again, thank you for holding this important hearing.

Hearing before the Senate Committee on Aging
A Time for Solutions: Finding Consensus in the Medicare Reform Debate
Wednesday, October 12, 2011

Testimony of Maya MacGuineas
Committee for a Responsible Federal Budget at the New America Foundation

Chairman Kohl, Senator Corker, Members of the Committee, thank you for inviting me here today to discuss changes for Medicare and the health care system. The fiscal challenges we face as a nation are immense, and the single largest cause in the long-term is growing health care costs, so this is a very important hearing and we thank you for holding it.

I am Maya MacGuineas, president of the bipartisan Committee for a Responsible Federal Budget and the director of the Fiscal Policy Program at the New America Foundation. Our co-chairs are Bill Frenzel, Charlie Stenholm, Jim Nussle and Tim Penny, and the board is made up of past directors of the Office of Management and Budget, the Congressional Budget Office, the Federal Reserve System, the Treasury Department, and the Budget Committees.

The fiscal problems we face as a nation are severe. What was once a long-term problem has become far more immediate due to the huge run up in our debt from running deficits over the past ten years, the economic downturn, and the policies of responding to the downturn. What is even more worrying than the current high debt level, is the projections that it will grow as a share of the economy--*indefinitely*. The debt is already presumably a drag on economic growth, and without changes, it will at some point result in a fiscal crisis.

Going forward, the growth of deficits will be driven by the aging of society and growing health care costs. The Congressional Budget Office projects that federal spending is set to grow to unprecedented and unaffordable heights in coming years, with health care costs and aging driving increases in spending on our major entitlement programs: Medicare, Medicaid, and Social Security. By 2035, health care cost growth will account for 36 percent of the increases in major entitlement program spending, and 56 percent of the increases by 2085, with aging accounting for the remainder.¹

Even under the optimistic scenario, where all the savings from the recent health care reforms stay in place through 2030 and reductions in Medicare payments to physicians, per the Sustainable Growth Rate, takes effect, Medicare costs will still grow to over 4 percent of GDP by 2021 and to over 6 percent of GDP in the 2030s.² According to the Congressional Budget Office's Alternative Fiscal Scenario, which assumes that various cost-controls put in place in the Affordable Care Act do not stick past 2021 and that lawmakers waive scheduled cuts to physician payments, Medicare costs are set to increase from about 3.7% of the economy in 2011, to 4.3 percent of GDP by 2021, and to over 7 percent of GDP in 2030s.³

¹ See Congressional Budget Office's "Long-Term Budget Outlook," Box 1-1, June 2011.
http://www.cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf

² Figures do not include Medicare offsetting receipts, which the Congressional Budget Office estimates will grow from about 0.5 percent of GDP today to roughly 1 percent of GDP in the 2030s.

³ The Congressional Budget Office, the Medicare actuaries, and other experts have raised concerns about the provisions to slow the growth of Medicare payments to providers, referred to as "productivity adjustments." Over

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

- There are many areas of overlap between a variety of fiscal plans on ways to save money in health care, and as many of them as possible should be implemented as quickly as possible (see CRFB's table of overlapping policies at <http://crfb.org/document/appendix-overlapping-policies-and-estimated-savings-across-fiscal-plans>).
- No matter how large a package of health care reforms we manage to pass, in all likelihood, more will have to be done later.
- We should put in place policies likely to generate savings even if they don't "score" well, or don't generate large savings until beyond a ten-year window.
- We should end the open-ended nature of spending on health care and include it in a budget, as we do other parts of federal spending.

Reforming Medicare

At \$555 billion (3.7 percent of GDP), Medicare is the costliest piece of the federal health care budget. Reducing costs, and more importantly, slowing the growth rate, will be a key to improving our fiscal future.

There have been many fiscal plans put forward over the past year to offer solutions on how to control health care costs and rising debt.⁴ From these, a number of options have emerged as the lowest hanging fruit of health care reform. We should implement as many of them as possible. We have to be realistic here, we actually don't know how to completely fix our health care cost problems. Unlike Social Security, where there are just a few policy levers that need to be moved and it is a question of picking which ones, with health care it is highly unlikely that we could put in place one comprehensive fix and declare the problem solved. Instead, we will likely return to health care reform many, many times. Therefore, we should do as much as we possibly can to control costs each round, and then assess the results to inform the next inevitable round of changes.

I will touch upon three groups of possible reforms to Medicare that we need to consider in order to address rising health care costs and population aging. The first will be policy reforms that can generate savings. These may well be the easiest to implement, but will do the least to change the path of the program. The second group will be policies that could potentially bend the health care cost curve down. The last will be larger structural reforms to Medicare.

"Savers" – These policies would bring down the levels of health care spending, and though growth might be the same going forward, it would be off of a lower base.

the long-term, public payments to health providers would differ markedly from private payments, and it is unclear whether lower public payments would be sustainable, and if so whether savings would come via greater efficiencies or reduced access or quality of care.

⁴ See the Committee for a Responsible Federal Budget's *Deficit Reduction Plan Comparison Tool* at <http://crfb.org/compare>.

1. **The Sustainable Growth Rate (SGR).** One of the most pressing Medicare issues from year-to-year still is the Sustainable Growth Rate, or SGR, which ironically has become quite unsustainable. Congress has routinely waived scheduled cuts to Medicare payments to physicians since they were set to begin in the early 2000s. As a result of this “kick the can” approach, the system has built up a larger debt that requires unrealistically deep cuts. Simply freezing Medicare payment updates to physicians will cost the federal government almost \$300 billion over the next ten years against a current law baseline, but reform can save us money compared to the costs of a ten-year freeze.

We need a permanent solution to this problem that makes tough choices and asks for sacrifices instead of creating continued uncertainty for providers and beneficiaries and leaves in place large fiscal liabilities. The Fiscal Commission, MedPAC, and other experts have called for lawmakers to develop a new formula to control Medicare payments that both improves the delivery of care and costs less. The Fiscal Commission recommended a modest negative reduction in updates while CMS designs a new formula for physician updates, with a hammer taking effect if a new system is not implemented by 2015. MedPAC proposed a payment structure that would freeze updates for primary care doctors but provide a negative update for specialists, while also recommending changes to the payment formula to encourage physicians to move away from fee-for-service Medicare into more efficient systems, such as Accountable Care Organizations.

2. **The Medicare Eligibility Age.** Gradually raising the Medicare eligibility age would both reduce federal health care costs and increase incentives for workers to remain in the labor force, thereby, increasing economic growth. Asking the youngest, healthiest, and most able to work of Medicare’s population to either continue to work to receive employer-sponsored health insurance or to enter into the new health care exchanges being set up by the Affordable Care Act to buy private insurance would better target limited public resources to those who need the support—not to mention the other benefits associated with a longer working life, including strengthened retirement security, a stronger labor market, and increased federal revenues.
3. **Reducing and Reforming Payment Rates.** Reducing Medicare payments to home health care providers; skilled nursing facilities; rural hospitals; and for hospital payments for bad debts, such as unpaid deductibles and copays could save up to \$70 billion this decade. In addition, Medicare currently overpays hospitals for costs associated directly and indirectly with graduate medical education, and reducing these payments could save another \$70 billion.
4. **Pharmaceutical Drug Payments.** While the Affordable Care Act reduced Medicare payments for most services, payments for prescription drugs under the Part D program were, for the most part, left unaffected and therefore remain an area with significant potential for savings. The Fiscal Commission recommended extending the discounts that drug companies are required to provide in the Medicaid program to people who are eligible for both Medicaid and Medicare and who receive drug coverage through Medicare Part D. The Domenici-Rivlin proposal recommended that drug companies be required to provide discounts for single source drugs where there is not competition among alternative drugs to control costs. Other reforms that could save money include changes to make generic drugs available to beneficiaries in a shorter time frame. Reforming these policies could lead to up to \$160 billion in savings this decade, reducing costs for both the federal government and beneficiaries.

5. **Further means-test premiums.** Medicare Part B premiums could be means-tested further by asking wealthier individuals to pay more into the system, which could yield up to \$40 billion in savings.
6. **Across the board premiums.** Going further than raising premiums on higher-income earners, raising the basic Part B premiums from 25 percent to 35 percent of program costs could save up \$240 billion over ten years.

“Benders” – These policies would bend the health cost care curve by bringing down the growth of health care costs as well as the level.

1. **Cost-sharing requirements.** Medicare was designed to include types of cost sharing rules – in the form of deductibles and co-payments – to encourage beneficiaries to use their care wisely and keep costs down. Unfortunately, in reality Medicare is a hodge-podge of various different deductibles, co-pays, and co-insurance rates that are too complex and confusing to establish the correct incentives. On top of that, many seniors purchase Medigap or other supplemental insurance to cover most or all of their cost-sharing – meaning that for many beneficiaries there is no real “skin in the game.”

In addition to reforming cost-sharing rules where they already exist, lawmakers could look at imposing cost-sharing in areas of Medicare where there currently are none. For example, a 10% coinsurance rate for home health episodes could save \$40 billion, and even more by imposing cost-sharing on clinical labs, skilled nursing facilities, and certain other areas of Medicare.

As an alternative, you could overhaul the entire cost-sharing system, as was recommended by the Fiscal Commission, Domenici-Rivlin, and the Lieberman-Coburn bill. For example, replacing all the cost-sharing rules in Medicare Part A and Part B with a single \$550 deductible and 20% co-insurance up to a \$5,500 catastrophic cap saves more than \$90 billion when combined with a restriction on Medigap plans. The Fiscal Commission and the Lieberman-Coburn proposal established an additional 5% co-insurance up to \$7,500 in total cost sharing -- and saved nearly \$130 billion.

2. **Restricting Medigap plans.** As I briefly touched on, restricting Medigap plans so that they cannot cover first-dollar expenses and limiting their other cost-sharing coverage provisions could save taxpayers more than \$50 billion over a decade. The ability of Medicare cost-sharing to control costs – either under current law or as proposed above – is limited by the purchase of supplemental private insurance plans (known as Medigap plans) that piggyback on Medicare. Medigap plans cover much of the cost-sharing that could otherwise constrain over-utilization of care and reduce overall spending. Surveys have found that beneficiaries with first dollar Medigap policies use 25% more services than other beneficiaries. A recent study by the Kaiser Family Foundation found that restricting Medigap coverage would actually reduce costs for most seniors by lowering annual premiums.⁵ Applying similar rules to TRICARE for Life – the Medigap plans for some former military personnel – would save another \$40 billion.

⁵ See Kaiser Family Foundation, “Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs.” July 2011. <http://www.kff.org/medicare/upload/8208.pdf>.

3. **Cost-control pilot programs in the Affordable Care Act.** The 2010 health care reform law put in place numerous pilot programs and demonstration projects to better control health care costs. Cost-sharing reforms can better incentivize cost-conscious behavior for patients, but we also need payment reforms for Medicare providers and that is what many of the pilots and demonstrations seek to highlight. Giving CMS the authority to accelerate programs, without congressional action, that successfully control costs without harming the quality of care and doing more to improve incentives for providers could help control costs nationally. Successful pilots could require changes in behavior that are unpopular with some providers, and giving CMS the ability to do this on its own could help ensure savings materialize.

To improve provider behaviors, most of the pilot programs focus on carrots to provide incentives for quality and cost improvements, such as higher payments for providers and bonuses, with fewer sticks for higher utilization or poor outcomes, such as penalties. Strengthening the sticks could help further incentivize improved outcomes and cost-controls.

4. **Medical malpractice laws.** Capping non-economic and punitive damages in medical malpractice cases, in addition to changing collateral source rules, could reduce medical costs throughout the health care industry.
5. **Coordination of dual eligible care.** Seniors who are eligible for both Medicare and Medicaid, often referred to as “dual eligibles,” have some health care services covered by Medicare and some by Medicaid, but neither system takes responsibility for looking at their entire care. Dual eligibles are more likely to have complicated health conditions, which require coordination of care. Several proposals, including the Fiscal Commission’s recommendations and Domenici-Rivlin, called for greater use of managed care.

“Structural Reforms” – These changes would change the basic structure of the Medicare system, by ending the basic design of open-ended health care spending.

1. **Independent Payment Advisory Board (IPAB).** Put in place by the Affordable Care Act, IPAB has been charged with limiting Medicare costs if per-beneficiary spending grows too quickly. However, IPAB is restricted from recommending reforms to certain elements of Medicare, such as taxes, Part B premiums, benefits, eligibility, and cost-sharing rules. Eliminating these special “carve outs” and giving IPAB the ability to make real, structural reforms could improve IPAB’s chances of successfully limiting spending growth. A strengthened IPAB could make recommendations on cost-sharing rules, provider payment reforms, benefit designs, and other reforms to better align cost-consciousness and higher quality health outcomes. Strengthening IPAB could also be a direct method to set limits on overall spending if its scope were expanded and if given the authority to recommend changes to all elements of Medicare.
2. **Premium support or competitive bidding.** Under premium support, the federal government would provide subsidies to individuals—adjusted for age, health, and other factors—in order to help them purchase health insurance in private markets. It would be a direct way to control the growth of health care spending by setting the rate at which federal subsidies could grow each year, as was proposed in the Ryan-Rivlin plan and at even lower growth rates in Paul Ryan’s budget proposal this spring.

A variation of pure premium support would be to introduce premium support alongside the traditional Medicare system, as was recommended in the bipartisan Domenici-Rivlin proposal. This plan would allow seniors to remain in the traditional Medicare program or to purchase private health insurance through a new Medicare Exchange, with a yearly limit on spending growth per beneficiary at the rate of GDP growth plus 1 percent. For people who choose to remain in traditional Medicare, if spending per beneficiary rises faster than the level specified, there would be an additional premium to cover the difference.

Finally, competitive bidding would offer an alternative to premium support, and would allow private plans to compete alongside Medicare in new health care exchanges, in which traditional fee-for-service Medicare would offer health plans in tandem with private bids. The idea is that added competition for Medicare would drive prices lower and help control cost growth over the long-term.

3. **A budget for Medicare.** The bottom line in restructuring health care spending is that we will probably not be able to keep an open-ended federally funded system for much longer. We should consider capping or limiting Medicare and other government health spending through a budget—just like we do for other areas of the government. As my colleague and CRFB board member Gene Steuerle has stated, “Simply put, you can’t maximize benefits relative to costs if costs are excluded from the equation.”⁶ To directly control costs and budget for Medicare, lawmakers could take several different approaches, including strengthening IPAB, transitioning to premium support or competitive bidding, or establishing triggers and procedural hurdles if Medicare was set to exceed the amount budgeted for it..

Other Health Care Reforms

While Medicare can and must play a critical role in controlling health care costs going forward, Medicaid and other health spending will also need to be part of the solution.

Possible Medicaid reforms include reducing tax gaming by states to increase the amount the federal government pays to them. Lawmakers should also consider reforms to the Medicaid state-matching formula to better encourage cost-consciousness and ownership on behalf of states and the federal government.

The federal government could also save billions in the coming years by reforming co-payments, premiums, and cost-sharing in TRICARE and TRICARE for Life, and from reforming the Federal Employees Health Benefits Program (FEHB).

Lawmakers also need to consider reforms to the tax exclusion on employer-provided health care, which accounted for roughly \$175 billion in forgone revenue last fiscal year – making it the largest federal tax expenditure of the more than \$1 trillion in lost revenue each year from special credits, deductions, exclusions, and other tax preferences. This would be one of the most promising changes we could make to our tax code and our health care system.

⁶ See Gene Steuerle Fiscal Times op-ed “Health Care Brawl: All or Nothing Doesn’t Work,” January 17, 2011. <http://www.urban.org/publications/901401.html>.

Medicare Reform in the Context of a Broader Fiscal Plan

While health care reforms, especially in Medicare, are a necessary component of solving our fiscal problems, they are not sufficient. To put the federal budget on a sustainable path, lawmakers will need to look at each area of the budget for savings, including from other mandatory programs, Social Security, and revenues.

Our country faces a fiscal gap in the trillions. Altogether, we need savings of \$3 - \$4 trillion this decade to put debt on a clear, downward path as a share of the economy. Many of the potential Medicare reforms I have discussed would take years to start yielding significant savings, given that beneficiaries would need time to adjust to changes. In the meantime, however, reforms to other mandatory programs and revenues can start yielding savings much more quickly than many reforms to health care and retirement programs.

Thank you to the Committee for all your work on this and the opportunity to appear here today, and I look forward to your questions.

Appendix: Overlapping Health Care Policies and Estimated Savings Across Fiscal Plans

Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions*	Lieberman-Coburn Health Proposal
Health Care						
Reform Medicaid Formula	\$15 billion from introducing a reduced blended Medicaid rate in 2017	\$770 billion from block granting Medicaid and indexing to CPI + population	Recommends consideration of block granting to meet long-term health cap	Replaces matching rates with reallocation of federal/state responsibilities beginning in 2018	\$100 billion from unspecified FMAP changes (with possible increased state flexibility)	
Reduce State Medicaid Gaming	\$26 billion from reducing Medicaid provider tax threshold		\$51 billion from phasing out Medicaid provider tax threshold		Under discussion as part of Medicaid reform	
Improve Dual Eligible Care			\$15 billion from mandating dual eligibles be placed in Medicaid managed care (with Medicare capitated payments)	\$8 billion from removing barriers for states to place dual eligibles in managed care	\$0-\$5 billion from better care coordination	
Enact Tort Reform		\$62 billion from aggressive reforms, including caps to non-economic and punitive damages	\$20 billion from reforms such as collateral source rule changes and consideration of aggressive reforms	\$62 billion from requiring states to cap non-economic and punitive damages		

Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions*	Lieberman-Coburn Health Proposal
Reduce Medicare Payments for Pharmaceutical Drugs	\$142 billion from prohibiting pay for delay for generic drugs (\$3b) shortening exclusivity for generics (\$4b), and drug rebates and drug rebates (\$135b)		\$55 billion by applying Medicaid drug rebates to low income seniors covered by Medicaid and Medicare Part D	About \$160 billion by expanding Medicaid drug rebates to Medicare Part D	Part D rebates proposed by Demis; other reforms, such as wholesale price (AWP) rules for Part D drugs and drug reclassifications also considered	
Increase Medicare Cost-Sharing	More than \$1 billion from increasing the Part B deductible and introducing a home health co-payment for new beneficiaries in 2017		\$65 to \$75 billion from a \$550 deductible, 20% co-insurance up to \$5,500, 5% co-insurance up to \$7,500, and catastrophic cap above that	About \$30 billion from a \$560 deductible, 20% co-insurance up to \$5,250 and catastrophic cap above that	Up to \$66 billion from clinical lab and skilled nursing facilities (SNF) / Home Health co-pays (though money could also come from payment reduction)	\$65 to \$75 billion from a \$550 deductible, 20% co-insurance up to \$5,500, 5% co-insurance up to \$7,500, and catastrophic cap above that
Increase Basic Medicare Premium				About \$240 billion from raising basic Part B premiums from 25% to 35% of costs (5-year phase-in)		About \$240 billion from raising basic Part B premiums from 25% to 35% of costs (5-year phase-in)
Increase Medicare Means-Testing	\$20 billion from increasing means-testing premiums and freezing brackets beginning in 2017				\$38 billion from freezing premium brackets after 2019 and increasing costs for high-earners	Increases catastrophic cap for high-earners and requires high-earners to pay 100% of premiums

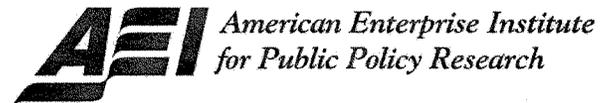
Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions	Lieberman-Coburn Health Proposal
Restrict Medigap Coverage	Over \$2 billion from a Medicare Part B surcharge on beneficiaries who purchase Medigap policies with low cost-sharing requirements for new beneficiaries beginning in 2017		\$53 billion from restricting first-dollar coverage of Medigap plans		Up to \$53 billion from restricting first-dollar coverage of Medigap plans	\$53 billion from restricting first-dollar coverage of Medigap plans
Enact Medicare Premium Support		Implements premium support for new retirees in 2022, with \$8,000 yearly subsidy indexed to inflation	Pilots premium-support in FEHB and recommends consideration of premium support after 2020	Implements premium support in 2018 for current and new retirees, allowing traditional Medicare to compete, indexed to GDP+1%		
Reduce Post-Acute Care Payments	\$42 billion from reducing payment updates for post-acute care providers and other reforms		\$9 billion from accelerating home health cuts under PPACA		Up to \$50 billion from cutting home health and SNF payments (though savings could come from cost-sharing)	\$9 billion from accelerating home health cuts under PPACA
Raise Medicare Eligibility Age			Recommends consideration of eligibility age increase to meet long-term targets		Raising age from 65 to 67 under discussion by Obama and Boehner	\$124 billion from raising the eligibility age to 67 between 2014 and 2025

Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions	Lieberman-Coburn Health Proposal
Reform TRICARE and/or TRICARE for LIFE	\$22 billion from a TRICARE for Life premium and higher TRICARE drug co-pays		\$43 billion from applying Medigap restrictions on first dollar coverage to TRICARE for Life		Up to \$17 billion from increasing drug co-pays under TRICARE	
Reform Federal Employees Health Benefits (FEHB) Program	\$2 billion from reforming FEHB pharmacy benefit contracting		\$22 billion from converting FEHB into premium support with fixed contribution amounts and having FEHBP subsidize Medicare premium instead of first dollar coverage		Up to \$11 billion from allowing FEHB benefit to subsidize Medicare premium instead of first dollar coverage	
Reduce Medicare Bad Debt Payments	\$20 billion from reducing bad debts payment		About \$25 billion from phasing out payments for bad debts		\$14-\$26 billion from phasing out payments for bad debts	\$25 billion from phasing out payments for bad debts
Changes in Special Hospital Payment Policies	\$15 billion from reducing Graduate Medical Education payments and rural hospitals		\$70 billion from reducing subsidies to hospitals for direct and indirect graduate medical education costs		\$28 billion, half from graduate (direct and indirect) medical payments and half from rural hospitals	
Reduce Spending from the Affordable Care Act	\$18 billion from correcting income insurance definition rules for subsidies and reducing spending on the Prevention and Public Health Fund	About \$50 billion from repealing the coverage and tax provisions of the Affordable Care Act	Calls for reforming or repealing the CLASS Act, which could cost up to \$87 billion in the first decade but reduce the deficit in future decades		\$10 billion from not allowing the Prevention and Public Health Fund to grow and repealing Frontier State Adjustments	

Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions*	Lieberman-Coburn Health Proposal
Reform the Sustainable Growth Rate (SGR)	Assumes a permanent freeze to reimbursement rates		\$36 billion (compared to a 10-year freeze) from a -1% update in 2014 and directing CMS to develop an improved payment formula that encourages care coordination and quality over quantity			Provides 3-year SGR fix to give time for lawmakers to develop new Medicare reimbursement mechanism for physicians

Note: This list is not exhaustive of overlapping policies.

*Estimates for BPC proposals extrapolated out to 2021, and estimated without interaction from premium support or Medicaid overhaul by CRFB staff.



Statement to the Senate Special Committee on Aging

A Time for Solutions: Finding Consensus in the Medicare Reform Debate

Joseph R. Antos, Ph.D.
Wilson H. Taylor Scholar in Health Care and Retirement Policy
American Enterprise Institute

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The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Thank you, Chairman Kohl, Ranking Member Corker, and members of the Committee for the opportunity to discuss Medicare reforms that can responsibly slow the growth of program spending and help set this country on a sustainable fiscal path.

I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute (AEI), a non-profit, non-partisan public policy research organization based in Washington, D.C. I am also a member of the panel of health advisers for the Congressional Budget Office (CBO), and I was formerly the Assistant Director for Health and Human Resources at CBO. My comments today are my own and do not necessarily reflect the views of AEI, CBO, or other organizations with which I am affiliated.

Numerous experts, commissions, and other organizations have advanced a variety of proposals intended to strengthen the economy and bolster the nation's fiscal health. There is a broad consensus that slowing the growth of federal health spending is essential if we are to achieve these goals. Federal health spending has grown faster than the economy since the creation of Medicare and Medicaid in 1965. Unless strong action is taken, federal health spending will continue to outpace the economy for the indefinite future.

Medicare reform is essential if we expect to avert this crisis. Medicare spending will double over the next decade, increasing from \$555 billion in 2011 to more than \$1 trillion annually in the early 2020s.¹ The first of the baby boom generation turned 65 this year and enrolled in Medicare. Over the next two decades, some 70 million people will move out of the work force, into retirement and into Medicare. That will place an increasing burden on the budget and on younger generations whose taxes support the program.

The Budget Control Act creates an opportunity for Congress to address these serious issues. The Joint Select Committee on Deficit Reduction is charged with developing a plan that would reduce the federal deficit by at least \$1.2 to \$1.5 trillion, and the Act provided expedited procedures to permit enactment of the plan by December 23. There is a growing consensus among policymakers and the public that Congress should adopt prudent policies to avert fiscal calamity.

Although Medicare reform remains controversial, there are also important areas of agreement, at least among policy experts. Immediate action can be taken on those areas of agreement, which would allow policymakers more time to focus on more fundamental disagreements. However, the adoption of less complex and less controversial deficit-reduction options does not absolve Congress from grappling with structural reforms necessary to ensure that Medicare will continue to provide essential health benefits for future generations.

A Basis for Agreement

The ongoing arguments about Medicare reform reflect fundamentally different philosophies about the role of government. Should reform rely more on the government to hold down the prices of health services, maintain quality standards, and protect consumers? Or

¹ Congressional Budget Office (CBO), *The Budget and Economic Outlook: An Update*, August 2011.

should reform give consumers a stronger voice in their own health care by allowing them to choose the coverage they want at a subsidized price they are willing to pay? Do we rely on government regulation or market incentives in Medicare and the health system?

As stark as those discussions often are, there are common elements that run through the arguments on both sides. The basic question is not all or nothing. The argument is over where we draw the line between government control and market incentives. There will be regulation, whether it is a government-issued rule or one established by a private insurer. There will be unpredictable changes in the health system as consumers, providers, insurers, and employers respond to those rules, no matter how tightly written they may seem. Consensus will develop around a Medicare reform that sets a reasonable balance between regulation and incentives.

Conceptual agreement is possible on other pressing issues. I offer three examples.

First, redistribution. Washington Post columnist Robert Samuelson calls Medicare “middle class welfare” because of the generous benefits provided to people who are economically secure and relatively healthy.² Medicare’s premiums for Part B and Part D are income-related, but higher-income beneficiaries still receive substantial benefits. Eugene Steuerle and Stephanie Rennane estimate that a single-earner couple turning 65 in 2010 will receive \$351,000 in Medicare benefits (measured in present value terms) over their lifetimes, but they paid only \$58,000 in payroll taxes and Medicare premiums.³ According to those calculations, higher income individuals pay more into the system but those payments do not approach the expected benefits paid by Medicare.

Many argue that the program should be made more progressive. The Heritage Foundation, for example, proposes to phase out the subsidy for Medicare benefits to beneficiaries with incomes over \$55,000 (for individuals) or \$110,000 (for couples).⁴ The subsidy is eliminated for individuals with incomes over \$110,000 or couples with incomes over \$165,000. They could enroll in Medicare but would receive no government contribution and pay full, unsubsidized premiums—not only for Part B and Part D, but for all the benefits covered by Medicare.

Other expert groups have proposed to increase the progressivity of Medicare, including the American Enterprise Institute, William Galston and Maya MacGuineas, Senators Lieberman and Coburn, and Alice Rivlin and Paul Ryan.⁵ Medicare already requires higher income beneficiaries to pay more, so that political barrier has been broken without undermining support

² Robert J. Samuelson, “Who rules America? AARP.” *Washington Post*, February 21, 2011, available at <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/20/AR2011022002482.html>.

³ C. Eugene Steuerle and Stephanie Rennane, “Social Security and Medicare Taxes and Benefits Over a Lifetime,” Urban Institute, June 2011, <http://www.urban.org/UploadedPDF/social-security-medicare-benefits-over-lifetime.pdf>.

⁴ Stuart Butler, Alison Acosta Fraser, and William Beach, *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, Heritage Foundation, Special Report #91, May 10, 2011, <http://www.heritage.org/research/reports/2011/05/saving-the-american-dream-the-heritage-plan-to-fix-the-debt-cut-spending-and-restore-prosperity>.

⁵ A summary of Medicare reform proposals is available from the Kaiser Family Foundation, “Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals,” September 23, 2011, <http://www.kff.org/medicare/upload/8124.pdf>.

for the program. In the face of rising fiscal pressure, there is no reason why Medicare's subsidy cannot be targeted on those who need help the most.

Second, honest Medicare budgeting. Public confidence in government depends greatly on whether policies are stable and predictable. Frequent changes in the way government is administered breeds cynicism and distrust. They cause individuals and businesses to take actions that are inefficient and wasteful to protect themselves against the uncertainty of the political process.

Medicare's sustainable growth rate (SGR) policy is a case in point. The SGR was established to limit the growth of Medicare physician spending. Beginning in 2003, Congress has overridden the reductions in payment rates determined by the SGR.⁶ Since the SGR formula is cumulative, the size of the required fee reduction has increased. As a result, physician payment rates will be reduced by 29.4 percent beginning January 1, 2012, unless Congress takes action.

There is widespread agreement that a nearly 30 percent cut in physician fees is unreasonable and universal expectation that Congress will do something about it, as it has for the past eight years. That expectation does nothing to reduce the anxiety or the intensive lobbying that accompanies this annual charade.

Previous legislation to defer the SGR reduction has granted relief for one year or less to minimize the amount of the budget offset needed to keep the policy budget neutral. According to CBO, a one-year "fix" setting the physician payment update to 0 for 2012 would cost \$22 billion through 2021.⁷ But enacting a fix one year at a time only appears to limit the budget impact.

The total additional spending over a decade will be the same whether the rate increases are made a year at a time or all at once. A permanent fix that builds no inflation into physician payments would cost \$298 billion through 2021, and one that allows payment rates to grow with the Medicare Economic Index would cost \$358 billion.

The Joint Select Committee has an opportunity to resolve this problem and place Medicare physician payment policy on a politically realistic path that future Congresses will be willing to accept. Another short-term fix makes the budget problem worse and further degrades public confidence in the legislative process.

Third, shared sacrifice. If a rising tide lifts all boats, a falling tide lowers them. CBO estimates that the debt to GDP ratio will reach 67 percent this year.⁸ The Committee for a Responsible Federal Budget estimates that the debt could reach 90 percent of GDP by 2021

⁶ Jim Hahn, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, Congressional Research Service, Report R40907, August 6, 2010, <http://aging.senate.gov/crs/medicare15.pdf>.

⁷ CBO, "Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies," June 16, 2011, http://www.cbo.gov/ftpdocs/122xx/doc12240/SGR_Menu_2011.pdf.

⁸ CBO, *The Budget and Economic Outlook: An Update*, August 2011.

under current policies.⁹ Medicare will have to do its part to help put the country on a sustainable course. That means cutting overall program costs even when there are circumstances, such as the physician payment problem, which call for increasing costs in a specific area. That will not be easy in the politically-charged context of health care.

On October 6, 2011, the Medicare Payment Advisory Committee (MedPAC) approved a set of recommendations to offset the cost of repealing the SGR.¹⁰ Those costs would be shared by physicians, other health professionals, providers in other sectors, and beneficiaries. Under the proposal, primary care physicians would be subject to a ten year payment freeze and payments to specialists would be cut 5.9 percent each year for three years followed by a seven-year payment freeze. Some of the other offsets come from durable medical equipment, hospitals and Medicare benefits to seniors.¹¹

This recommendation for shared sacrifice was not welcomed by those asked to sacrifice.¹² The American Medical Association and 42 other medical organizations argued that the SGR repeal should not be funded by instituting other kinds of cuts in Medicare physician payment.¹³ Richard Umbdenstock, president and CEO of the American Hospital Association, wrote that offsetting the cost of the SGR repeal with Medicare cuts to hospitals and other providers is an approach equivalent to “robbing Peter to pay Paul.”¹⁴

That comment characterizes one of the problems with regulatory price-setting schemes that are typical in Medicare: organizations attempt to gain financial advantage at the expense of others (“rob Peter to pay Paul”) through the political process. This “rent-seeking” behavior diverts resources from productive activities that could provide greater value to patients.

Near-Term Options

A realistic Medicare reform package that could be considered by the Joint Select Committee must satisfy several requirements. The provisions must yield substantial program savings within the ten-year budget window, which means that they can be implemented fairly rapidly and their capacity to reduce program spending is reasonably clear-cut. At the same time, however, at least some provisions must be forward-looking and, ultimately, risky. Business as usual with a few tweaks will not be effective in preserving Medicare for the long term.

⁹ Committee for a Responsible Federal Budget, “What Needs to Come Out of the Debt Ceiling Negotiations,” June 21, 2011, http://crfb.org/sites/default/files/What_Needs_to_Come_Out_of_Debt_Ceiling_Negotiations.pdf.

¹⁰ Stephanie Bouchard, “MedPAC approves SGR repeal proposal,” Healthcare Finance News, October 7, 2011, <http://www.healthcarefinancenews.com/news/medpac-approves-sgr-repeal-proposal>.

¹¹ Rich Daly, “MedPAC offers path to SGR repeal,” Modern Healthcare, October 6, 2011, <http://www.modernhealthcare.com/article/20111006/NEWS/310069989/medpac-offers-path-to-sgr-repeal#>.

¹² Bob Herman, “AHA, AMA Urge MedPAC to Consider Other Issues With SGR,” Becker’s Hospital Review, October 5, 2011, <http://www.beckershospitalreview.com/racs/-/icd-9/-/icd-10/aha-ama-urge-medpac-to-consider-other-issues-with-sgr.html>.

¹³ American Medical Association, Letter to Glenn M. Hackbarth, October 3, 2011, <http://www.ama-assn.org/resources/doc/washington/sgr-repeal-specialty-sign-on-letter.pdf>.

¹⁴ Richard J. Umbdenstock, Letter to Glenn M. Hackbarth, October 3, 2011, <http://www.aha.org/advocacy-issues/letter/2011/111004-let-umbdenstock-hackbarth.pdf>.

Near-term provider cuts. Because Medicare is a complex program with many moving parts, the list of budget options to reduce program spending that could be implemented quickly is lengthy and highly technical. Refinements in payment systems, adjustments in coding medical services, modifications in conditions under which Medicare will pay for a service, and changes in administrative oversight could produce scoreable savings that can help the Joint Select Committee's bottom line.

The Medicare Payment Advisory Commission's initial list of proposals to offset the cost of abolishing the SGR is illustrative.¹⁵ MedPAC combed through their own previous reports as well as budget options proposed by the Congressional Budget Office, the Department of Health and Human Services, and the President's budget to identify 29 specific provisions offering a combined ten-year savings of \$233 billion.

Nearly all of MedPAC's offsets are aimed at health care providers and suppliers. Fee-for-service payments hospitals, home health agencies, and post-acute care facilities would be trimmed. Payments would be cut for inappropriate readmissions. Prior authorization would be required for medical imaging performed by physicians identified as high utilizers. Payment reductions would be taken for durable medical equipment. Pharmaceutical manufacturers would be required to pay a rebate to the federal government (in effect, a tax) for sales of prescription drugs to low-income beneficiaries under Medicare Part D.

None of those provisions change the underlying economic incentives associated with fee-for-service medicine. Most tighten payment rates without attempting to promote greater efficiency or better value for patients. Prior authorization attempts to directly curb unnecessary use of services, but this approach only backfills against flawed payment incentives that are the root cause of the problem.

Simple price cuts do not address the problems inherent in Medicare's fee-for-service payment system. Since traditional Medicare sets thousands of prices, it is impossible for the program to set relative prices of specific services to accurately reflect their value to the patient. As a result, relatively overpriced services will be in greater use when there is a choice, and that makes the care delivered less efficient.

The political virtues of provider cuts cannot be denied. By focusing budget pressure on providers and suppliers, policymakers can assert that benefits would not be reduced and patients would not be harmed. That claim may appear to be true, at least when such cuts are modest and of short duration. Providers and medical suppliers will see their incomes and profit margins decline, and may not immediately respond to lower Medicare payments by changing the way they function.

Just as there is no free lunch, there are no painless Medicare cuts. One of the main goals of Medicare reform is to free up resources for other uses, but that comes with consequences. Lower payments eventually result in reduced access to services and slower introduction of new

¹⁵ Medicare Payment Advisory Commission (MedPAC), "Draft Offset List," September 15, 2011, <http://www.medpac.gov/transcripts/Draft%20Offset%20List%20for%20Public.pdf>. At the time this statement was written, the final list of recommendations approved by MedPAC was unavailable.

technology and innovative treatments. Some short-term options have greater long-term impact on access and medical progress than others. That should be weighed carefully by the Joint Select Committee as they develop their final deficit reduction package.

Near-term program restructuring. Other deficit reduction options that could produce scoreable savings in the near term would directly affect some aspects of Medicare's interaction with beneficiaries. Such changes would be relatively modest and would not fundamentally change the way traditional Medicare operates. They include increasing cost-sharing requirements, instituting targeted care management programs for high-cost patients, and raising Medicare premiums. A politically more ambitious option is to raise Medicare's eligibility age.

Cost-sharing requirements—deductibles, copayments, and coinsurance—are included in the design of Medicare and other health insurance to promote more prudent use of services. Requiring some out-of-pocket payment increases the patient's cost awareness, which reduces utilization. Private plans typically have a single deductible that applies to all covered services and a simple structure of coinsurance or copayments after the deductible has been satisfied.

In contrast, Medicare's cost-sharing requirements are complex and uneven. Traditional Medicare has a \$1,132 deductible for inpatient hospital stays and a separate \$162 deductible for outpatient services. It also has a complex set of coinsurance requirements that vary depending on the medical service, and it places a lifetime limit on the number of days a beneficiary is covered for inpatient hospital care. Traditional Medicare does not provide protection against catastrophic health care costs; beneficiaries are potentially at risk for unlimited costs even though they are covered by Medicare.

Most beneficiaries in traditional Medicare are protected from the confusion and financial risk of this structure through supplemental insurance—Medigap, retiree coverage, or Medicaid. As a result, most beneficiaries pay little or nothing out of pocket for their care. The patient's lack of cost awareness coupled with fee-for-service incentives for the provider has contributed to the rapid growth of Medicare spending.

Options include simplifying Medicare's cost-sharing requirements (by creating a single deductible and uniform coinsurance on all services, and adding catastrophic coverage to traditional Medicare) and prohibiting Medigap plans from covering Medicare's deductible.¹⁶ Alternatively, Medigap premiums could be taxed to recapture some of the additional Medicare spending induced by the supplemental coverage.

Simplifying cost-sharing requirements and limiting the scope of Medigap coverage would increase cost awareness and reduce some use of services. Such a policy would rationalize Medicare's benefit structure and reduce federal spending modestly.

Introducing some elements of managed care into fee-for-service Medicare could be more effective in controlling program costs and has the potential to improve patient outcomes. Medicare spending is highly concentrated, with the top 10 percent of beneficiaries accounting for

¹⁶ See Option 21 in CBO, *Reducing the Deficit: Spending and Revenue Options*, March 2011.

more than 60 percent of the program's cost.¹⁷ These high-cost patients have chronic diseases and multiple comorbidities. Lack of coordination among providers leads to duplicative testing, unnecessary services, and inadequate patient follow-up that results in poor care and high costs.

Specialized chronic care management programs that target these complicated patients have the potential to reduce costs.¹⁸ Such programs create a virtual network of providers who see the patient, facilitate the exchange of medical information, and monitor the patient to encourage better adherence to the treatment plan. Medicaid programs have used such programs for their high-cost patients, including dual eligibles who are enrolled in Medicare and Medicaid. A similar approach in Medicare would not fundamentally change the operation of the traditional fee-for-service program.

This policy is obviously much more complex than simply cutting provider payments or charging patients higher copayments. If the policy is successful, program savings could be substantial but lack of certainty means a low CBO savings score.

Unlike the previous two policy approaches, raising Medicare premiums would do nothing to reduce the cost or use of services.¹⁹ Options include raising the basic Medicare Part B premium, increasing the amount that higher-income beneficiaries are required to pay, or establishing a new income-related premium for Part A.

The effect of these premium options is to narrow somewhat the gap between the amount Medicare beneficiaries pay into the program over their lifetimes and the benefits they receive. As Steuerle and Rennane show, beneficiaries stand to receive hundreds of thousands of dollars more in benefits than the total of their payroll taxes and premium payments.²⁰ Premiums, no matter how high they are set, will not catch up to program costs.

There has been considerable discussion about raising Medicare's eligibility age despite the predictable pushback from interest groups.²¹ The rationale for this policy is to reinforce the incentive to delay retirement created by increasing Social Security's full retirement age. Opponents of the provision argue that raising the eligibility age shifts Medicare's costs to seniors and others, and may also result in higher total health spending.²²

CBO estimates \$125 billion in budget savings through 2021 if eligibility is raised from 65 to 67 starting in 2014.²³ More gradual implementation, such as increasing the eligibility age by

¹⁷ CBO, *High-Cost Medicare Beneficiaries*, May 2005.

¹⁸ See note 57 in Robert A. Berenson and John Holahan, "Preserving Medicare: A Practical Approach to Controlling Spending," Urban Institute, September 2011, http://www.urban.org/health_policy/url.cfm?id=412405.

¹⁹ Medicare premiums are treated as offsetting receipts in the budget, which appears as a reduction in program outlays. However, raising premiums does not reduce the use of services or their cost.

²⁰ C. Eugene Steuerle and Stephanie Rennane, "Social Security and Medicare Taxes and Benefits Over a Lifetime," Urban Institute, June 2011, <http://www.urban.org/UploadedPDF/social-security-medicare-benefits-over-lifetime.pdf>.

²¹ Tracy Jan, "Hospitals push hike in age for Medicare," Boston Globe, September 30, 2011, http://articles.boston.com/2011-09-30/news/30230360_1_eligibility-age-hospitals-face-medicare.

²² Paul N. Van de Water, "Raising Medicare's Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States, and Employers," Center on Budget and Policy Priorities, August 23, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3564>.

²³ See Option 18 in CBO, *Reducing the Deficit: Spending and Revenue Options*, March 2011.

one or two months a year instead of the full two year increase immediately or making the increase effective for people who will not turn 65 for a few years, would reduce the savings.

Some who would be affected by this policy and would otherwise be uninsured could qualify for subsidized coverage in the health insurance exchanges under the Affordable Care Act (ACA). However, the Medicaid expansion mandated by ACA does not apply to people 65 and older. If Congress extends the Medicaid expansion and holds states harmless from the additional cost, that would eliminate much of the savings from this option.

Long-Term Reform

Medicare's uncapped entitlement and fee-for-service incentives have driven a steady but unsustainable rise in program spending. Both patients and providers benefit from increasingly effective and increasingly expensive treatments, and workers are stuck with the bill. Neither patients nor providers have much incentive to hold down costs or provide services in the most efficient way. As the baby boom generation retires, financial burdens on those remaining in the workforce will continue to grow to unaffordable levels. Fundamental changes are needed if we expect to preserve Medicare for the future.

Without structural reforms, Medicare spending will crowd out other federal spending priorities, including support for education, energy, and infrastructure. Budgetary restraint is needed, but it cannot be enforced solely through the supply side of the market. To be effective, consumers must become active purchasers through premium support.

The Federal Employees Health Benefits Program is an example of premium support. Members receive a subsidy to purchase insurance from a wide selection of plans offering a core set of benefits. More expensive plans are available, but the extra premium is paid solely by the enrollee without additional subsidy. That gives an incentive to consumers to select lower-cost plans, and it gives an incentive to the plans to negotiate lower prices with providers and improve their efficiency. Competition drives plans to offer consumers better value as a way to increase market share.

The adoption of the premium support model for Medicare is controversial and complicated. Opponents argue that private plans do not have the market power needed to negotiate payment rates as low as fee-for-service Medicare.

A widely misinterpreted report from CBO on the House Republican premium support plan advanced by Rep. Paul Ryan seems to support that assertion.²⁴ The report indicates that an average 65-year-old Medicare beneficiary in 2022 would spend \$6,000 more under the Ryan plan than under traditional Medicare.

CBO assumed that Medicare would be able to impose ever-increasing reductions in fee-for-service payment rates with no reduction in beneficiary access to care. CBO also assumed that private plans under premium support would have no choice but to pay ever-increasing

²⁴ Douglas W. Elmendorf, Letter to Hon. Paul Ryan, April 5, 2011, http://www.cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf.

amounts to providers to maintain that same level of access. No changes in health care delivery or system efficiency are assumed under premium support, despite the pressure on plans to lower their costs in order to remain competitive in the market.

Both assumptions cannot be correct. Either price controls in traditional Medicare will cause a massive breakdown in service, as suggested by the Medicare actuaries, or premium support will cause the adoption of more efficient delivery methods.²⁵

There are numerous issues that must be resolved before premium support could be adopted. The following issues are among the most controversial.

- *Growth rate.* Options include tying the growth in federal support for Medicare to growth in GDP, in the CPI, or in health spending in the rest of the economy. An alternative approach, discussed below, would avoid assigning an arbitrary growth rate on the subsidy, which instead would be tied to actual plan bids in the Medicare market.
- *Traditional Medicare option.* Traditional Medicare might remain a plan option for all beneficiaries or limited to those who are enrolled as of a specific date.
- *Price setting in traditional Medicare.* Some proposals would allow traditional Medicare price mechanisms to operate.
- *Risk selection.* Specific issues include questions about the adequacy of risk adjustment methods and concern that plan designs would attract healthier enrollees and exclude those with greater health needs.

Most of these issues could be resolved by replacing the current flawed bidding process used for Medicare Advantage with competitive pricing for all plans, including traditional Medicare. This approach eliminates arbitrary limits on the Medicare subsidy that could make health care unaffordable for beneficiaries. It also maximizes the benefits of competition without disadvantaging beneficiaries living in rural areas or other markets dominated by one or two large providers.

Under this approach, private plans and traditional Medicare in each geographic market area would submit bids that estimate their cost per enrollee to cover the standard Medicare benefit package. The winning bid would be the lowest amount that cleared the market. The combined capacity of all plans submitting a bid at or below the winning bid would be sufficient to accommodate all Medicare enrollees in that market.

The subsidy for an average beneficiary in each market would be set to cover a fixed percentage of the winning bid. That percentage could be the current average subsidy, which is about 85 percent, or it could be reduced to produce larger budget savings. The subsidy would be risk adjusted, with higher subsidies going to lower income beneficiaries and those with greater health needs.

In some markets, traditional Medicare would be the lowest bidder. That is most likely in rural areas that have one or two hospitals and a limited number of other health care providers,

²⁵ John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services, May 13, 2011, <http://www.cms.gov/ReportsTrustFunds/downloads/2011TRAAlternativeScenario.pdf>.

and markets in which a few key providers have substantial leverage to negotiate high payment rates. In other markets where there is more robust competition among providers, private plans will be able to undercut Medicare's cost.

By tying Medicare subsidies to actual bids, all beneficiaries are assured that they will have access to at least one health plan that offers the standard set of benefits at no more than the Part B premium. Seniors who wanted a more expensive plan would pay the additional premium out of their own pockets.

Robert Coulam, Roger Feldman, and Bryan Dowd have estimated that a fully implemented competitive pricing system for Medicare would save \$550 billion over ten years.²⁶ If this system was phased in gradually, they estimate the savings at \$460 billion.

This approach is a fair test of the competitive model. It preserves full government funding for basic Medicare benefits. Unlike other proposals that set arbitrary limits on the subsidy, beneficiaries would not be exposed to the risk of excessive cost growth. Full competitive bidding also preserves traditional Medicare as an option. Unlike the current system, traditional Medicare would compete fairly without any special advantages over private plans—and private plans would have no special advantages over traditional Medicare.

Conclusion

The United States is on an unsustainable fiscal path. The recession that ended in 2009 was the longest downturn since the Great Depression. The ensuing recovery has been anemic, with unemployment hovering around 9 percent. Federal budget deficits in the last three years have been higher than at any time since World War II. According to the Congressional Budget Office, the \$1.3 trillion budget deficit that it projects for 2011 will be the third-largest shortfall in the past 65 years.²⁷

The Joint Select Committee on Deficit Reduction is charged with developing a comprehensive plan for long-term debt and deficit reduction. That plan will include recommendations for more aggressive cost reduction in Medicare than would occur under the sequester specified in the Budget Control Act. Its provisions will include many of the near-term options proposed by the Medicare Payment Advisory Commission, the Congressional Budget Office, and other expert groups. Such options are necessary because they can be implemented expeditiously and can garner favorable budget scores. But many of those options do nothing to address Medicare's fundamental structural defects.

The Committee has an obligation to think more broadly. If we ever hope to bend Medicare's cost curve, we must change the financial incentives that drive program spending to increasingly unaffordable levels. A well-designed premium support program can take full

²⁶ Robert F. Coulam, Roger Feldman, and Bryan E. Dowd, "Better Prices--Through Competitive Bidding--Can Help Solve Medicare's Fiscal Crisis," American Enterprise Institute, August 26, 2011, <http://www.aei.org/article/104058>, and Robert F. Coulam, Roger Feldman, and Bryan E. Dowd, *Bring Market Prices to Medicare*, AEI Press, November 2009.

²⁷ Congressional Budget Office, *The Budget and Economic Outlook: An Update*, August 2011.

advantage of market competition to drive out unnecessary spending and increase Medicare's value to beneficiaries. This is safe and reasonable approach to lowering program costs. It is also our best hope for real Medicare reform.

Testimony before the U.S. Senate Special Committee on Aging
John Holahan
October 12, 2011

Thank you for the opportunity to testify before the U.S. Senate Special Committee on Aging. The views I express are mine alone and should not be attributed to the Urban Institute or any of its sponsors. The testimony is based on a paper written with Dr. Robert Berenson, "Preserving Medicare: A Practical Approach to Controlling Spending."¹ In this testimony, I would like to make three basic points:

- 1) While in Medicare spending is projected to grow by about 7 percent per year over the next decade, spending growth on a per enrollee basis is now projected to be relatively modest, certainly lower than projected increases in private insurance premiums.
- 2) Proposals that would essentially privatize the Medicare system will not work as intended; they will increase overall expenditures and shift more spending onto Medicare beneficiaries.
- 3) Finally, there are a number of other reforms that while not restructuring Medicare would substantially lower its future expenditure path.

First, it is important to place Medicare spending growth in perspective. Medicare spending is projected to grow at about 6.5 percent per year over the next decade; about 2 percentage points faster than the growth in the U.S. economy – 4.7 percent per year.² Medicare spending growth would increase by about 0.7 percentage faster if physician fees were allowed to increase with the Medicare Economic Index (MEI) rather than face large cuts.³ At the same time, however, the Center for Medicare and Medicaid Services (CMS) Actuaries project that spending per enrollee will increase only by 3.5 percent per year over the 2010-2019 period.⁴ The gross domestic product (GDP) per capita is projected to grow at about the same rate – 3.8 percent – over the same period.

¹ Berenson RA and Holahan J. *Preserving Medicare: A Practical Approach to Controlling Spending*. Washington, DC: Urban Institute, Oct 2011. http://www.urban.org/health_policy/url.cfm?id=412405

² Centers for Medicare and Medicaid Services, Office of the Actuary, September 2010.

³ Centers for Medicare and Medicaid Services, Office of the Actuary. "Projected Medicare Expenditures Under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers." Baltimore, MD: CMS, 13 May 2011.

⁴ Centers for Medicare and Medicaid Services, Office of the Actuary, September 2010.

A major reason for the projected 6.5 percent rate of growth in Medicare spending is the substantial increase in enrollment due to the retirement of the baby boomers who have started turning 65 this year. Medicare enrollment is projected to grow by almost 3 percent per year over the next decade. The influx of 65 to 75 year old group brings in a lower-cost group of individuals and lowers the rate of growth in the average cost of a Medicare beneficiary.

But much of the explanation of a relatively slow rate of growth by historical standards is due to the provisions in the Affordable Care Act (ACA) that will reduce Medicare spending increases. These include reductions in payments to Medicare Advantage plans, hospitals, skilled nursing facilities and home health services. According to the CMS Actuaries, these provisions will reduce the rate of spending growth by 1 percentage point. The CMS Actuaries have argued that these cuts are not sustainable, for example, that Medicare hospital payments will not keep up with the growth in hospital costs. However, this argument assumes that hospitals have little choice but to incur these costs. The reality is more complicated; there has been a growing research literature that shows that the ability to shift costs onto private payers is limited. Except in highly concentrated markets, the evidence is that hospitals will in fact restrain cost growth to live within available revenues.⁵

The 3.5 percent rate of growth also does not account for increases in Medicare physician fees. It is inconceivable that Medicare physician fees will be permitted to fall by 29 percent in 2012. CMS actuaries estimate that allowing Medicare physician fees to increase by MEI would increase Medicare spending by \$300 billion over ten years and increase Medicare's projected growth rate by 0.7 percent.⁶

We conclude that while Medicare spending growth is relatively modest on a per enrollee basis, overall spending growth is still substantial and there is still room for savings and these should be pursued aggressively but carefully.

⁵ Robinson J. "Consolidation and the Transformation of Competition in Health Insurance." *Health Affairs*, 23(6): 11-24, 2004; Frakt AB. "How Much Do Hospitals Cost Shift? A Review of the Evidence." *Milbank Quarterly*, 89(1): 90-130, 2011; Wu V. "Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997." *International Journal of Health Care Finance and Economics*, 10(1): 61-83, 2009. DOI: 10.1007/s10754-009-9071-5.

⁶ Centers for Medicare and Medicaid Services, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers."

Second, proposals such as that made by Congressman Paul Ryan, Chairman of the House Budget Committee, will not work as intended.⁷ The plan would essentially turn Medicare over to private insurers, Medicare would provide subsidies towards the purchase of a private insurance plan, with beneficiaries responsible for additional costs over and above Medicare payments. While this would not begin until 2022, it is worth considering the fundamental approach. Medicare spending would clearly decline under this and other such proposals because Medicare's contributions would be limited to the growth of inflation regardless of the actual increase in health care spending. The Congressional Budget Office (CBO) has estimated that the total societal cost of providing Medicare benefits would actually increase under the proposal, primarily because the elimination of the traditional Medicare program would shift beneficiaries into more costly private plans. CBO estimates that private plans are more costly than traditional Medicare for two reasons: higher administrative costs and higher provider payment rates. CBO estimates that average spending in traditional Medicare would be 28 percent below spending for the same package of benefits from a private insurer in 2022 (even with a physician fee fix). Medicare beneficiaries would pay 68 percent of the cost of these higher premiums.⁸

The higher provider payment rates used by private insurers relative to traditional Medicare reflects the difficulty private plans have in negotiating payment rates with providers. Recent years have seen a substantial increase in consolidation in the hospital industry and increasingly among physicians. As hospital and physician consolidation increases, the difficulty the private plans have in negotiating provider payment rates has increased and will continue to do so. Traditional Medicare sets prices based on systems developed for both hospital and physician payments and uses its large market presence to set rates that most providers accept. We have concluded that the market power that Medicare has is necessary to control cost growth. Given the central role of payment rates as a health care cost driver and the market failure produced by growing provider consolidation that increases prices, it is essential to maintain and even enhance the traditional Medicare program as we seek savings. This of course does not preclude

⁷ Congressional Budget Office. "Long Term Analysis of a Budget Proposal by Chairman Ryan." Washington, DC: CBO, 5 April 2011.

⁸ Congressional Budget Office. "Long Term Analysis of a Budget Proposal by Chairman Ryan."

encouraging private plans to compete with the traditional Medicare plan, as now in the Medicare Advantage program.

The other problem with privatization approaches is that they ignore the skewness of the Medicare expenditure distribution; that is, a small percentage of Medicare beneficiaries account for the bulk of spending. Using data for 2006, we estimate that 69 percent of Medicare beneficiaries spend less than \$5,000 per year.⁹ They account for 12 percent of Medicare spending. \$5,000 is roughly an equivalent in 2006 to the health savings account (HSA) out-of-pocket limit of \$5,950 faced by the non-elderly in 2011. Any proposal for a private option would probably include out-of-pocket caps in this range. The fact that only 12 percent of the spending is attributed to those who spend less than \$5,000 a year and 23 percent to those who spend below \$10,000 means that the reach of higher cost-sharing levels is likely to be limited. In other words, 77 percent of expenditures is on roughly the 20 percent of Medicare population whose expenditures exceed \$10,000 a year; they would face virtually no out-of-pocket costs for most of their expenditures. Thus, the impact of requiring Medicare beneficiaries to have more “skin in the game” would contribute only a limited amount to slowing Medicare spending growth.

Third, there are a number of other policies that could be implemented without a major restructuring. To begin with, we should build on a series of demonstration programs that have been part of the ACA. There are a number of options for testing new payment approaches that move away from volume-based payments and change current incentives that lead many providers to provide unneeded and sometimes inappropriate services. These new models include patient-centered medical homes and accountable care organizations. We do not know yet how well these reforms will work, but they represent changes in the delivery system that offer considerable promise.

We recognize that there is a need for savings in the near term while experimentation with these broader system reforms takes place. CBO and Medicare Payment Advisory Commission (MedPAC) have both identified a number of reforms. Proposals to consider include reducing home health and skilled nursing facility payment updates which could yield savings of about \$40

⁹ Urban Institute Analysis of the Medicare Current Beneficiary Survey, 2006 Cost and Use File.

billion over 10 years.¹⁰ CBO has proposed increased cost-sharing for home health services which would reduce spending by nearly \$50 billion over 10 years.¹¹ The National Commission of Fiscal Responsibility and Reform (Bowles-Simpson) recommended extending Medicaid drug rebates to Medicare dual eligibles, a policy which would provide an estimated savings of \$49 billion over 10 years.¹²

There are several other possibilities that could provide near-term savings. The premium structure in Medicare is quite complicated with separate premiums for Part B and Part D; it is also unfair.¹³ Using Part B as an example, those who are dually eligible for both Medicare and Medicaid pay little or no premiums depending on their incomes. Those with incomes above 134 percent of the federal poverty line (FPL) pay the full Part B premium (25 percent of expenditures) until income levels of \$85,000 for individuals and \$170,000 for couples (825 percent of FPL and 1,310 percent of FPL respectively). At that point Medicare premiums double; for individuals and couples with higher income levels they increase even further. Part D has similar income-related premium surcharges.

This means that those with incomes above 134 percent of FPL and below 300 percent of FPL pay extremely high premiums as a percentage of income, with premiums as a percentage of income declining until the \$85,000/\$170,000 levels are reached. This is in sharp contrast to the premium schedule in the ACA where premiums are 2 percent at an income level of 133 percent of FPL and increase to a maximum of 9.5 percent at an income level of 300 percent of FPL. It is possible to develop a premium schedule that is more like that in the ACA. This would lower premiums for those with incomes below 300 percent of poverty and increase them gradually up to the \$85,000/\$170,000 income levels. This could be done in a way that could provide increased revenues. CBO has estimated savings of \$241 billion over ten years from increasing the Part B

¹⁰ Congressional Budget Office, *Budget Options Volume I: Health Care*. Washington, DC: CBO, December 2008; Medicare Payment Advisory Commission, "Home Health Services," in *Report to Congress: Medicare Payment Policy*. Washington, DC: Medicare Payment Advisory Commission, March 2011.

¹¹ Congressional Budget Office. *Budget Options Volume I: Health Care*.

¹² The National Commission on Fiscal Responsibility and Reform. *The Moment of Truth*. Washington, DC: The National Commission on Fiscal Responsibility and Reform, December 2010.

¹³ Zuckerman S, Shang B, Waidmann T. "Policy Options to Improve the Performance of Low Income Subsidy Programs for Medicare Beneficiaries." Washington, DC: The Urban Institute, forthcoming.

premium from 25 percent to 35 percent of program costs but this does not include the low-income protections we propose.

In addition, Medicare cost-sharing could be restructured with an out-of-pocket cap on all expenditures. Medicare benefits include substantial cost-sharing in the form of hospital deductibles and co-insurance for physician and out-patient services. There is no upper limit on the amount of Medicare cost-sharing expenses that beneficiaries incur. As a result, beneficiaries often seek supplemental Medigap coverage sometimes to pay for the routine cost-sharing associated with services, but also to obtain catastrophic coverage for long-duration spells of illness. There is research evidence that Medigap policies reduce the effective cost-sharing in Medicare, increasing utilization and Medicare spending.¹⁴ The deductible and cost-sharing structure could be substantially changed and made more uniform across different benefit categories.¹⁵ For example, there could be a single deductible of say \$1,000 with 20 percent cost-sharing for Part A and Part B up to an out-of-pocket cap at around current HSA levels. The out-of-pocket cap could apply to Part D as well. There should be greater cost-sharing protections for those with incomes below 250 percent of FPL as in the ACA. The National Commission on Fiscal Responsibility and Reform proposed a similar approach and estimated savings of \$110 billion over 10 years, while providing better protection for those who need it.¹⁶ In principal, this would make the purchase of Medigap coverage much less necessary. The Bowles-Simpson Commission also recommended that Medigap policies not be permitted to cover the first \$500 of cost-sharing and limit coverage to 50 percent of the next \$5,000.¹⁷ The notion is to restructure Medicare so that supplemental insurance is both unnecessary and financially unattractive.

Another option is to increase the age of eligibility to 67. This should be done gradually so that individuals can anticipate and prepare for the change. This option is only feasible when the ACA is fully implemented because many in this age group would have great difficulty getting coverage in the current health insurance market. ACA includes provision for 3:1 age rating

¹⁴ Remler DK, Atherly AJ. "Health Status and Heterogeneity of Cost-Sharing Responsiveness: How Do Sick People Respond to Cost-Sharing?" *Health Economics*, 12(4):269-80, April 2003.

¹⁵ Davis K, Moon M, Cooper B, Schoen C. "Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries." *Health Affairs*, Web Exclusive: w5-442-w5-454, 5 October 2005; Zuckerman S, Shang B, Waidmann T. "Reforming Beneficiary Cost Sharing to Improve Medicare Performance." *Inquiry*, 47: 215-225, Fall 2010.

¹⁶ The National Commission on Fiscal Responsibility and Reform. *The Moment of Truth*.

¹⁷ *Ibid*.

which will limit premiums for those age 65 to 66. The ACA also provides for income-related premium and cost-sharing subsidies, thus providing substantial protection for low-income individuals who would now purchase private plans through exchanges.¹⁸ Those with higher incomes would pay more than they do today. Employers would also spend more as would states. Some of the savings to the federal government from phasing out Medicare for those 65-66 would be offset by subsidies in exchanges. But after accounting for these shifts, the CBO has estimated that gradually raising Medicare eligibility age to 67 beginning in 2014 would reduce federal outlays by \$125 billion between 2012 and 2021.¹⁹ It is important to note that national health expenditures overall would be higher because private plans are more costly than traditional Medicare.²⁰ We emphasize again that the ACA provisions, including health insurance exchanges, age rating, and substantial subsidies to support the purchase of insurance for low income individuals are essential to making this kind of change in Medicare.

Medicare should also take greater responsibility for the acute care services provided to dual eligibles. We estimate that dual eligibles spent \$305 billion in 2010 between Medicare and Medicaid.²¹ Over the next decade, spending on dual eligibles will amount to over \$4 trillion. Dual eligibles are primarily low-income individuals, and many have multiple chronic conditions. There is often little coordination of their care. The split of responsibility between Medicaid and Medicare adds to inefficient and unnecessary spending. There have been many efforts to develop programs that successfully coordinate care for these individuals. Not all have proven to be successful but many recent efforts have been. Successful demonstration programs have shown considerable savings from reduced hospital admissions, readmissions, drug utilization, skilled nursing facility days and use of specialists.²² Most of the savings are on acute care services

¹⁸ Neuman T, Cubanski J, Waldo D, Eppig F, Mays J. *Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform*. Henry J. Kaiser Family Foundation, March 2011.

¹⁹ Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*. Washington, DC: CBO, March 2011. <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>.

²⁰ Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*.

²¹ Holahan J, Schoen C, McMorro, S. "The Potential Savings from a Federal Chronic Care Management Policy." Washington, DC: The Urban Institute, forthcoming.

²² Grumbach K, Bodeheimer T, Grundy P. "The Outcomes of Implementing the Patient Centered Medical Home Interventions." Washington, DC: Patient Centered Primary Care Collaborative, August 2009; Naylor MD, Brooten DA, Campbell RL, Maislin G, McCauley KM, Sanford Schwartz J. "Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized Clinical Trial." *Journal of the American Geriatrics Society*, 52: 675-84, 2004; Coleman EA, Parry C, Chalmers S, Min SJ. "The Care Transitions Intervention: Results of a Randomized Clinical Trial." *Archives of Internal Medicine*, 166: 1822-28, 2006; Wheeler JRC, Janz NK, Dodge JA. "Can a Disease Self-Management Program Reduce Health Care Costs? The Case of Older Women with Heart Disease." *Medical Care*, 41(6): 706-15, 2003; Brown R. "The Promise of Care Coordination: Models that

covered by Medicare. This strongly implies that Medicare not Medicaid should take the lead role in developing policies and programs to manage the acute care services of dual eligibles.²³ Even small percentage reductions in spending could yield savings of more than \$200 billion over 10 years simply because expenditures on dual eligibles are so large.²⁴

Finally, we believe that Medicare would benefit from increased expenditures on Medicare administration. The Centers for Medicare and Medicaid Services have taken on many new responsibilities over the years but have had relatively little increase in staffing.²⁵ Considerable savings could be achieved, for example, from devoting more resources to detecting and preventing fraud within the Medicare program.²⁶

Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses." Washington, DC: The National Coalition on Care Coordination, 2009.

²³ Feder J, Clemans-Cope L, Coughlin T, Holahan J, Waidmann T. "Refocusing Responsibility For Dual Eligibles: Why Medicare Should Take The Lead." Washington, DC: The Urban Institute, Oct 2011.

<http://author.urban.org/UploadedPDF/412418-Refocusing-Responsibility-For-Dual-Eligibles.pdf>

²⁴ Holahan et al. "The Potential Savings from a Federal Chronic Care Management Policy."

²⁵ Stanton TS. "The Administration of Medicare: A Neglected Issue." *Washington and Lee Law Review*, 60(4): 1373-1416, Fall 2003.

²⁶ Budetti P. "Public and Private Sector Efforts to Detect Fraud in the Health Care System." Statement before United States House Committee on Ways and Means, Subcommittee on Oversight, 2 March, 2011.

A Time for Solutions:
The Medicare Reform Debate

Testimony before the United States Senate
Special Committee on Aging

Douglas Holtz-Eakin
President, American Action Forum*

October 12, 2011

*The views expressed herein are my own and do not represent the position of the American Action Forum. I am grateful to Han Zhong and Michael Ramlet for assistance.

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

- Medicare must be reformed. The Medicare *status quo* is dangerous to the fiscal health of the federal government, the U.S. economy, and especially Medicare beneficiaries. Medicare faces a projected 10-year cash flow deficit of \$4.14 trillion¹ In addition, the Independent Payment Advisory Board is a dramatic policy error that will exacerbate reimbursement problems and stifle innovation.
- The Joint Select Committee on Deficit Reduction has an important opportunity to undertake bipartisan reforms. I recommend:
 - Fix the Sustainable Growth Rate (SGR)
(10-Yr Deficit Increase= \$195.2 – \$388.5 billion)²
 - Repeal the CLASS Act
(10-Yr Deficit Increase = \$86.0 billion)³
 - Limit Medical Malpractice Torts
(10-Year Deficit Reduction = \$64.0 billion)⁴
 - Reduce Federal Payments for Graduate Medical Education Costs
(10-Year Deficit Reduction = \$69.4 billion)⁴
 - Raise the Eligibility Age for Medicare to 67
(10-Year Deficit Reduction = \$124.8 billion)⁴
 - Expand Cost Sharing Structures for Medicare and Medigap Insurance
(10-Year Deficit Reduction = \$32.2 billion – \$92.5 billion)⁴
 - Increase Basic Premiums for Medicare Part B
(10-Year Deficit Reduction = \$241.2 billion)⁴

The total 10-year deficit reduction would amount to as much as \$480 billion.

- Over the longer term, Congress should adopt a premium support approach to Medicare. Premium support models in varying forms and structures have been at the heart of every major bipartisan deficit reduction proposal.

¹ Authors Calculations. "2011 Medicare Trustees Report."

<https://www.cms.gov/reportstrustfunds/downloads/tr2011.pdf>.

² Congressional Budget Office. "Medicare's Payments to Physicians."

http://www.cbo.gov/ftpdocs/122xx/doc12240/SGR_Menu_2011.pdf

³ Congressional Budget Office. "Analysis of the Major Health Care Legislation."

<http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>

⁴ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options"

<http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

The Need for Medicare Reform

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

These shortfalls lie at the heart of past deficits and projected future debt accumulation. As shown in Table 2, between 2001 and 2010, cumulative Medicare cash flow deficits totaled just over \$1.5 trillion, or almost 28 percent of the total federal debt accumulated in the hands of the public during the past decade.

Going forward, the situation is even worse. By 2020, the cumulative cash-flow deficits of \$6.2 trillion will constitute 35 percent of the nation's total debt accumulation. Including interest costs, accumulated Medicare's debt will be responsible for over 37 percent of the debt in the hands of the public.

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

One of the most dangerous aspects of the *status quo* is the creation of the Independent Payment Advisory Board (IPAB). It should be repealed immediately.

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

By statute, IPAB cannot directly alter Medicare benefits. Instead, the more likely threat to patients is that the IPAB will be forced to limit payments for medical services. In effect, it will be able to decide which treatments are covered for patients and set price controls for each treatment.

This is especially troubling as IPAB may choose to focus on new treatments for conditions like Alzheimer's or Parkinson's, which will likely have rapid cost growth, particularly in the early stages of their market introduction. Because IPAB is directed to focus on areas of "excess cost growth," it will make these treatments a primary target.

Table 1: Annual Medicare Cash Flows

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Annual Medicare Cash Flows										
Projected Total Income	273.2	284.8	291.6	317.7	357.5	437	461.9	480.8	508.2	486.1
Total Payroll Taxes Collected	152	152.7	149.2	156.7	171.4	181.3	191.9	198.7	190.9	182.0
Total Premiums Collected	24.2	26.7	29.0	33.4	40.0	48.9	53.5	58.2	65.2	61.80
Annual Cash Revenues	176.20	179.40	178.20	190.10	211.40	230.20	245.40	256.90	256.10	243.80
Annual Expenditures	-240.9	-265.7	-280.7	-308.9	-336.4	-408.3	-431.5	-468.2	-509	-522.8
Total Medicare Net Cash-Flow	\$ (64.70)	\$ (86.30)	\$ (102.50)	\$ (118.80)	\$ (125.00)	\$ (178.10)	\$ (186.10)	\$ (211.30)	\$ (252.90)	\$ (179.00)
Annual Medicare Cash Flows										
Projected Total Income	529.9	575.8	642	700.7	786.4	808.1	914	1000.6	1094.9	1205.5
Total Payroll Taxes Collected	202.95	217.47	239.10	257.34	284.80	288.59	321.88	347.48	374.95	401.43
Total Premiums Collected	71.01	78.08	88.11	97.32	110.53	114.95	131.58	145.77	161.43	182.03
Annual Cash Revenues	273.96	295.55	327.21	354.66	395.33	403.54	453.45	493.25	536.37	583.46
Annual Expenditures	-568.30	-597.90	-648.40	-703.40	-757.90	-826.40	-902.30	-985.10	-1078.80	-1192.60
Total Medicare Net Cash-Flow	\$ (294.34)	\$ (302.35)	\$ (321.19)	\$ (348.74)	\$ (362.57)	\$ (422.86)	\$ (448.85)	\$ (491.85)	\$ (542.43)	\$ (609.14)

Source: 1997-2011 CMS Medicare Trustees Reports and Authors Calculations

Table 2: Medicare and the Total Debt Held by Public

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CEO & Author's Calculations										
Cumulative Medicare Cash Flow	\$ (472.50)	\$ (538.80)	\$ (661.40)	\$ (780.10)	\$ (905.10)	\$ (1,083.20)	\$ (1,269.30)	\$ (1,480.60)	\$ (1,733.50)	\$ (2,012.50)
Interest Paid on Medicare Shortfall	\$ (23.73)	\$ (25.77)	\$ (26.55)	\$ (33.24)	\$ (38.83)	\$ (51.50)	\$ (58.76)	\$ (94.29)	\$ (95.45)	\$ (64.11)
Total Medicare Debt Burden	\$ (496.23)	\$ (564.57)	\$ (687.95)	\$ (813.34)	\$ (943.93)	\$ (1,135.10)	\$ (1,328.06)	\$ (1,534.89)	\$ (1,788.95)	\$ (2,076.61)
Total Debt Held by Public	\$ 3,320	\$ 3,540	\$ 3,913	\$ 4,296	\$ 4,592	\$ 4,829	\$ 5,035	\$ 5,803	\$ 7,545	\$ 9,018
Total Medicare Cash Flow as % Debt	14.2%	15.8%	16.9%	18.2%	19.7%	22.4%	25.2%	25.5%	23.0%	22.3%
Total Medicare Burden as % Debt	14.9%	16.5%	17.6%	18.9%	20.6%	23.5%	26.4%	26.4%	23.7%	23.0%
CEO & Author's Calculations										
Cumulative Medicare Cash Flow	\$ (2,306.84)	\$ (2,609.19)	\$ (2,930.38)	\$ (3,279.12)	\$ (3,641.69)	\$ (4,064.55)	\$ (4,513.39)	\$ (5,005.24)	\$ (5,547.66)	\$ (6,156.80)
Interest Paid on Medicare Shortfall	\$ (77.28)	\$ (97.84)	\$ (121.61)	\$ (149.20)	\$ (180.26)	\$ (216.44)	\$ (243.72)	\$ (270.28)	\$ (299.57)	\$ (332.47)
Total Medicare Debt Burden	\$ (2,384.12)	\$ (2,707.03)	\$ (3,051.99)	\$ (3,428.32)	\$ (3,821.95)	\$ (4,280.99)	\$ (4,757.11)	\$ (5,275.52)	\$ (5,847.24)	\$ (6,489.27)
Total Debt Held by Public	\$ 10,430	\$ 11,598	\$ 12,386	\$ 12,996	\$ 13,625	\$ 14,358	\$ 15,064	\$ 15,767	\$ 16,557	\$ 17,392
Total Medicare Cash Flow as % Debt	22.1%	22.5%	23.7%	25.2%	26.7%	28.3%	30.0%	31.7%	33.5%	35.4%
Total Medicare Burden as % Debt	22.9%	23.3%	24.6%	26.4%	28.1%	29.8%	31.6%	33.5%	35.3%	37.3%

Source: 1997-2011 CMS Medicare Trustees Reports; Congressional Budget Office March 2011 Baseline; and Authors Calculations

Furthermore, about one-half of all healthcare spending is off limits until after 2020, which is likely to lead to disproportionate and uneven application of IPAB's scrutiny and payment initiatives.

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

All of this suggests that IPAB is a potent mechanism for undesirable policy. Thus, it is particularly troubling that IPAB is unaccountable. Its decisions must be honored by the Secretary of HHS and it is structured to discourage Congress from making the important policy choices.

The IPAB is at best a band-aid on out-of-control Medicare spending and at worst a threat to physician autonomy and patient choice. Saving Medicare from ruin requires nothing short of total and comprehensive reform. Adding in more cuts to a broken system does not make it any less broken. The IPAB proposals will be short-term fixes and cuts. We need long-term thinking and long-term solutions. We need to move the focus from merely containing costs to focus on how to get the most value for our healthcare dollars.

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

Recommendations for Immediate Reform

1. Fix the Sustainable Growth Rate (SGR) mechanism.

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

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

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

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

Table 3: Impact on Physician Access for Medicare Enrollees

As a result of the uncertainty created by the June 1, 2010 Medicare Part B payment reduction of 21.3 percent, later reversed by Congress, which decisions DID your practice implement in June?	
Stopped accepting new Medicare patients	11.8%
Reduced the number of appointments for new Medicare Patients	29.5%
Reduced the number of appointments for current Medicare patients	15.5%
Ceased treating all Medicare patients	1.1%

Which business considerations are currently under discussion by your practice due to this reimbursement uncertainty?	
Limit the number of new Medicare patients	67.2%
Refuse to accept new Medicare patients	49.5%
Cease treating all Medicare patients	27.5%
Reduce the number of appointments for current Medicare patients	56.1%

Source: September 2010 MGMA Sustainable Growth Rate Survey

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

The Fiscal Commission recognized the dire need for a meaningful fix to the SGR rate with its very first healthcare recommendation. Table 4 includes the commission's recommendation as well as other options scored by the Congressional Budget Office.

Beyond fixing the rate, Congress should also seek to develop an improved physician payment formula that rewards care coordination across multiple providers and settings. An effective fix would lead to a payment system that pays doctors based on quality instead of quantity of services.

Table 4: Options for Fixing the SGR

PROPOSAL	Plan Description	10-Year Score
CBO Specified Update Options	<ul style="list-style-type: none"> ➤ 0% update through 2021 ➤ MEI* update through 2021 ➤ 1% update through 2021 ➤ 2% update through 2021 	<ul style="list-style-type: none"> \$297.6 billion \$358.1 billion \$342.1 billion \$388.5 billion
CBO Reset Options	<ul style="list-style-type: none"> ➤ Reset SGR targets at 2010 spending level ➤ Reset SGR targets at 2010 spending level and use GDP+1% in target ➤ Reset SGR targets at 2010 spending level and use GDP+2% in target 	<ul style="list-style-type: none"> \$195.2 billion \$247.0 billion \$301.0 billion
Fiscal Commission's SGR Policy Recommendation	➤ Freeze update through 2013, -1%; update for 2014, reinstate the SGR in 2015 at 2014 spending level	\$261.7 billion

* MEI = Medicare Economic Index projections according to CBO

2. Repeal the CLASS Act.

In addition to an immediate fix to the SGR, the President's Fiscal Commission recommended urgent reform, or outright repeal, of The Community Living Assistance Services and Supports Act (CLASS Act). This is because the CLASS ACT is certain to substantially increase the federal deficit due to an actuarial design that is structurally unsound. Healthy individuals who desire long-term care insurance are likely to find better quality products at lower prices in the private market, leaving the federal government on the hook for the most expensive and highest risk beneficiaries.

The Fiscal Commission highlighted the budgetary risk of creating a federal long-term care entitlement when it recommended a capped allotment be instituted for the federal share of Medicaid payments toward long-term care. Simply put implementing the CLASS Act undermines any serious effort at reducing the federal deficit.

In the current 10-year budget window, the CLASS Act is misleadingly scored as budgetary savings due to the fact that beneficiaries must pay premiums for five years before receiving any benefits. The initial excess revenue hides a sea of red ink to come in subsequent decades. Because the CLASS Act delivers phantom savings on paper, it will require \$86 billion in budgetary offsets over the next decade to repeal it.

Fortunately, there has been growing bipartisan support for repeal. Senate Budget Chairman Kent Conrad (D-ND) has called the CLASS Act “A Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of.” Chairman Conrad and six other Senators have sent a letter to Majority Leader Reid in which they state, “We have grave concerns that the real effect of the provision would be to create a new federal entitlement with large, long-term spending increases that far exceed revenues.”

3. Limit Medical Malpractice Torts.

This option would impose certain nationwide curbs on medical malpractice torts. Many states have enacted some or all of these limits, whereas others have very few restrictions on malpractice claims. Tort limits include caps on noneconomic damage (e.g. pain and suffering) and on punitive damages; a shortened statute of limitations; restrictions on the use of joint-and-several liability; and changes to rules regarding collateral sources of income.⁵

Malpractice tort limits would reduce total healthcare spending in two ways: First, by reducing the average size of malpractice awards, tort limits would reduce the cost of malpractice insurance premiums. This reduced cost of malpractice insurance paid by providers would flow through to health plans and patients in the form of lower prices for health care services. Second, as noted above, tort limits would also reduce utilization of healthcare services by a small amount as practitioners prescribing somewhat fewer services when faced with less pressure from potential malpractice claims.

In terms of federal healthcare spending, the CBO estimates the percentage decline in Medicare to be larger than the decline in spending for other federal healthcare programs or for national health spending. This estimate is based on empirical evidence showing that the impact of tort reform on the use of healthcare services is greater for Medicare than for the rest of the health system.⁶

This option would reduce mandatory spending for Medicare, Medicaid, Children’s Health Insurance Program (CHIP), subsidies for coverage purchased through health insurance exchanges, and the Federal Employees Health Benefits program by a total of roughly \$50 billion over the 10-year budget window.⁷

⁵ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁶ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁷ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

Both the Fiscal Commission and the Domenici-Rivlin taskforce strongly supported medical malpractice reform. Table 5 provides additional detail on each malpractice recommendation as well as a scored proposal by the Congressional Budget Office.

Table 5: Options for Malpractice Reform

PROPOSAL	Plan Description	10-Year Score
CBO Option: Limit Medical Malpractice Torts	<ul style="list-style-type: none"> ➤ A cap of \$250,000 on awards for noneconomic damages ➤ A cap on awards for punitive damages of \$500,000 or two times the value of awards for economic damages, whichever is greater ➤ A statute of limitations of one year from the date of discovery of the injury for adults, and three years for children ➤ A fair-share rule (replacing the rule of joint-and-several liability) under which a defendant in a lawsuit would be liable only for the final award that was equal to that defendant's share of responsibility for the injury. ➤ Permission to introduce evidence of income from collateral sources (such as life insurance payouts and health insurance) at trial 	-\$49.5 billion
Fiscal Commission Option: Medical Malpractice Reform	<ul style="list-style-type: none"> ➤ Modify the "collateral source" rule to allow outside sources of income collected as a result of an injury ➤ Imposing a statute of limitations—perhaps to one to three years—on medical malpractice lawsuits ➤ Replacing joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury ➤ Creating specialized "health courts" for medical malpractice lawsuits ➤ Allowing "safe haven" rules for providers who follow best practices of care 	-\$17 billion
Domenici-Rivlin Option	<ul style="list-style-type: none"> ➤ Require states to cap awards for noneconomic and punitive damages for medical malpractice ➤ Start large-scale testing of systemic reforms, including safe harbors for practices that conform to accepted guidelines, specialized malpractice courts, and administrative proceedings to resolve disputes 	-\$48 billion

4. Reduce Federal Payments for Graduate Medical Education (GME) Costs.

Under Medicare's prospective payment system for inpatient medical services, hospitals with teaching programs receive additional funds for costs related to graduate medical education (GME). For every increase of 0.1 in the ratio of full-time residents to the number of beds, indirect medical education (IME) adjustments provide hospitals with about 5.5 percent more in reimbursement payments.

Of concern, the Medicare Payment Advisory Commission (MedPAC) has consistently found that the IME calculation overstates the effect of teaching status on incurred costs. In its most recent report to Congress, MedPAC estimates that an IME adjustment of about 2 percent more closely reflects the indirect costs that teaching hospitals actually incur.⁸

Teaching hospitals also receive GME payments from both the federal government and the states through the Medicaid program. CBO estimates that total mandatory federal spending for hospital-based GME in 2010 was about \$10 billion -- \$9.5 billion through Medicare and \$500 million through Medicaid.⁹

Table 6 highlights a scored proposal completed by the CBO as well as the details of the Fiscal Commission's proposed reduction toward graduate medical education (GME) payments.

Table 6: Proposals to Reduce GME Payments

PROPOSAL	Plan Description	10-Year Score
CBO Option: Consolidate and Reduce Federal Payments for GME at Teaching Hospitals	<ul style="list-style-type: none"> ➤ Consolidate all mandatory federal spending for GME into a grant program for teaching hospitals. ➤ Total funds available for distribution would be based on the 2011 aggregate payments for direct graduate medical education (DGME) and Medicaid GME plus 2011 aggregate payments for IME reduced to reflect a 2.2 percent IME adjustment ➤ Total funding for the grant program would grow with inflation as measured by the consumer price index for all urban consumers minus 1 percentage point per year. ➤ Payments would be apportioned according to the number of residents at a hospital and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients 	-\$69.4 billion
Fiscal Commission Option: Reduce excess payments to hospitals for medical education	<ul style="list-style-type: none"> ➤ Bring GME payments in line with the costs of medical education by limiting hospitals' direct GME payments to 120 percent of the national average salary paid to residents in 2010 ➤ Updated annually thereafter by chained CPI and by reducing the IME adjustment from 5.5 percent to 2.2 percent, which MedPAC has estimated would more accurately reflect indirect costs. 	-\$60 billion

⁸ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁹ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

5. Raise the Age of Eligibility for Medicare to 67.

The usual age of eligibility for Medicare benefits is 65, although certain people qualify for coverage earlier. (Medicare is available to persons under age 65 who have been eligible for disability benefits under Social Security for at least 24 months and to those with end-stage renal disease.) Because of increases in life expectancy, the average length of time that people are covered by Medicare has risen significantly since the program began in 1965. This trend, which increases the program's costs, is expected to continue.¹⁰

The issue of raising the age of eligibility for Medicare became a more politically viable possibility during the July 2011 debt ceiling negotiations when President Obama reportedly offered an increase in the Medicare age eligibility in exchange for Republican movement on increasing tax revenues.¹¹ The proposal was also discussed earlier in the year as part of the House Budget Resolution and prior to that as a provision in the Ryan-Rivlin Healthcare Plan which grew out of Fiscal Commission hearings. For additional information on the plan specifics see Table 7.

The Congressional Budget Office estimates that options outline in Table 7 would reduce federal spending by roughly \$125 billion over the next decade. The estimates primarily reflect a reduction in federal spending on Medicare and a slight reduction in outlays for Social Security retirement benefits. Those reductions would be partially offset by an increase in federal spending on Medicaid and an increase in federal subsidies to purchase health insurance through the new insurance exchanges that are scheduled to be established in 2014.

The option would reduce outlays for Social Security retirement benefits by inducing some people to delay their application for such benefits (some people apply for Social Security benefits at the same time they apply for Medicare) and by encouraging some people to delay retirement to maintain their employment-based health insurance coverage until they became eligible for Medicare. The option could also affect the number of people who apply for disability benefits; those effects are expected to be quite small and are not included in this estimate.¹²

The increase in Medicare's eligibility age would boost federal spending on Medicaid in two ways. First, some of the people who were no longer receiving Medicare benefits would have income below 138 percent of the federal poverty level and would therefore sign up for and receive Medicaid benefits instead. (Under current law, that income threshold applies only to people under age 65, but for this option CBO assumed that that age limit would increase in tandem with the Medicare eligibility age.) Second, people over 65 who would have been enrolled in both Medicare and Medicaid (those for whom Medicaid pays Medicare's premiums and cost sharing, and covers certain services not covered by Medicare) would

¹⁰ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

¹¹ Sam Stein. "Obama Offered to Raise Medicare Eligibility Age as Part of Grand Debt Deal." *The Huffington Post*. July 11, 2011.

¹² Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

instead have Medicaid as their primary source of coverage until they reached the new Medicare eligibility age.¹³

Subsidies for insurance coverage purchased in the new health insurance exchanges would also increase under this option because some of the people whose eligibility for Medicare was delayed would receive those subsidies instead.

Federal revenues under this option would decrease by a small amount over the 2012–2021 period; however, those effects are not included in this estimate. That decline in revenues would occur primarily because some employees and retirees whose eligibility for Medicare was delayed would accept coverage through their employer instead. (Active workers who are eligible for Medicare have the option of accepting or rejecting coverage from their employer; for those who accept such coverage, Medicare is the secondary payer.) Most of the resulting increase in employers' spending on health insurance would lead to reductions in taxable wages for active workers or would reduce employers' taxable profits; the remainder would probably be passed along to enrollees in the form of higher premiums. In addition, employers that provided retiree coverage to former workers before they became eligible for Medicare would incur higher costs to the extent that they provided such coverage over a longer period. Although the option could cause some employers to reduce or eliminate such retiree coverage, no changes of that sort are incorporated in this estimate. Federal revenues also would be reduced because a small portion of the subsidies provided through the health insurance exchanges are tax expenditures rather than outlays. CBO did not estimate any increase in tax revenues resulting from workers who delay retirement because total employment in the economy was assumed to remain unchanged that assumption is consistent with CBO's standard approach to cost estimates.

By 2035, Medicare's spending under this option is estimated to be about 7 percent below what it would be in the absence of this policy change—5.5 percent of gross domestic product rather than 5.9 percent. On the basis of estimates for the 2012–2021 period, CBO anticipates that about one-quarter of those Medicare savings would be offset by the increases in federal spending described above.¹⁴

¹³ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

¹⁴ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

Table 7: Options for Raising the Medicare Eligibility Age

PROPOSAL	Plan Description	10-year score
CBO Option: Raise the Age of Eligibility for Medicare to 67	<ul style="list-style-type: none"> ➤ Raise the age of eligibility by two months every year beginning with people who were born in 1949 (who will turn 65 in 2014) until the eligibility age reached 67 for people born in 1960 (who will turn 67 in 2027) ➤ Thereafter, the eligibility age would remain at 67 ➤ Those increases are similar to those already under way for Social Security's full retirement age (FRA) – that is, the age at which workers become eligible for full retirement benefits – except that scheduled increases in the FRA include a 12-year period during which the FRA remains at 66. ➤ The eligibility age for Medicare would remain below Social Security's Fra until 2020, when both would be age 66 for people born in 1954; from that point on, the two would be identical. 	-\$124.8 billion
Ryan-Rivlin Plan:	<ul style="list-style-type: none"> ➤ Starting in 2021, the age of eligibility for Medicare would increase by two months per year until it reached 67 in 2032 ➤ Eligibility for the Medicare program would not change for people who are currently 55 or older; as a result, the average age and costs of enrollees remaining in the current Medicare program would increase over time. ➤ However, enrollee premiums under Medicare would be adjusted to equal what they would be under current law. 	<i>Proposal goes into effect outside of the 2021 budget window</i>
House Budget Resolution: The Path to Prosperity	<ul style="list-style-type: none"> ➤ Starting in 2022, the age of eligibility for Medicare would increase by two months per year until it reached 67 in 2033 	

6. Change Cost Sharing Structures for Medicare and Medigap

Cost sharing structures for traditional fee-for-service (FFS) Medicare plans vary significantly depending on the type of service provide – hospitalization, skilled nursing facility, home health care. These variations create inconsistent incentives for patients to weigh relative costs when choosing among options for treatment. Moreover, if Medicare patients incur extremely high medical costs, they may face a significant amount of cost sharing because the program does not place a limit on those expenses.¹⁵

Due to the fact that the cost sharing requirements in FFS can be substantial, about 90 percent of enrollees purchase supplemental coverage. About 15 percent of those FFS enrollees qualify for Medicaid, 40 percent obtain coverage through an employer,

¹⁵ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

and about 40 percent pay for a Medigap policy – an individual insurance policy that is designed to cover most or all of Medicare’s cost sharing requirements.

This means that Medicare enrollees with supplemental coverage are liable for only a fraction of the cost of additional care expenses, which places a heavy financial burden on the federal government. Consequently, federal costs for Medicare could be reduced if Medigap plans were restructured so that policyholders faced some cost sharing for Medicare services but still had a limit on their out-of-pocket costs.¹⁶

Table 8 outlines three proposals for changing the cost sharing structures for Medicare and Medigap as they were evaluated by the CBO. The table also covers alternative approaches proposed by the Coburn-Lieberman plan and the Fiscal Commission. There has been near universal agreement across all bipartisan deficit and healthcare reform plans that greater cost sharing is needed for supplemental insurance and Medigap.

The argument in favor of this option is that it would appreciably strengthen incentives for more prudent use of medical services—both by raising the initial threshold of health care costs that most Medicare beneficiaries face and by ensuring that more enrollees pay at least a portion of all subsequent costs up to the out-of-pocket limit. Because medigap plans would be barred from paying the first \$550 of an enrollee’s cost sharing liabilities (under the second and third alternatives), the costs borne by medigap plans would decrease, and therefore so would the premiums that the medigap plans charge. Another argument in support of this option is that it would provide greater protection against catastrophic costs. Capping enrollees’ out-of-pocket expenses would especially help people who develop serious illnesses, require extended care, or undergo repeated hospitalizations but lack supplemental coverage for their cost sharing.

Table 8: Options for Changing the Cost Sharing Structures of Medicare

PROPOSAL	Plan Description	10-Year Score
CBO Option 1: Establish Uniform Cost Sharing Only	<ul style="list-style-type: none"> • \$550 deductible covering all Part A and Part B • Uniform coinsurance rate of 20% between \$550 and \$5,500 • \$5,500 cap on enrollee cost sharing liabilities (medigap covers everything beyond) 	-32.2 billion
CBO Option 2: Restrict Medigap Plans Only	<ul style="list-style-type: none"> • Enrollee pays for first \$550 of expenses • Limit coverage to 50% between \$550 and \$5,500 in Medicare cost sharing • \$5,500 cap on enrollee cost sharing liabilities (medigap covers everything beyond) 	-\$53.4 billion

¹⁶ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

CBO Option 3: Establish Uniform Cost Sharing and Restrict Medigap Plans	<ul style="list-style-type: none"> • Enrollee pays for first \$550 of expenses • Uniform coinsurance rate of 10% between \$550 and cap if enrollee has another form of supplemental insurance • Uniform coinsurance rate of 20% between \$550 and cap if enrollee does not have another form of supplemental insurance 	-92.5 billion
Coburn-Lieberman Plan: Unified Annual Deductible & Annual Out-of-Pocket Limit	<ul style="list-style-type: none"> • Enrollee pays for first \$550 of expenses • Uniform coinsurance rate of 20% between \$550 and \$5,500 • Uniform coinsurance rate of 5% between \$5,500 and \$7,500 • \$7,500 cap on enrollee cost sharing liabilities (medigap covers everything beyond) 	-\$130 billion
Fiscal Commission Plan: Restrict first-dollar coverage in Medicare supplemental insurance	<ul style="list-style-type: none"> • Enrollee pays first \$500 • Limit coverage to 50% between \$500 and \$5,500 in Medicare cost sharing • \$5,500 cap on enrollee cost sharing liabilities (medigap covers everything beyond) 	-\$38 billion

7. Increase Basic Premiums for Medicare Part B

Medicare Part B allows beneficiaries to obtain coverage for physician and other outpatient services by paying a monthly premium. When the program began in 1966, the premium was intended to finance 50 percent of Part B costs per aged enrollee, with the remainder funded by general revenues. Subsequent legislation, however, reduced that share, and premium collections fell to less than 25 percent of program spending. The Balanced Budget Act of 1997 permanently set the Part B premium at about 25 percent of Part B spending per aged enrollee. General revenues still fund the remainder of Part B spending. (These calculations are based on costs for enrollees age 65 and older and do not include costs for people who qualify for Medicare before age 65 because of a disability.)¹⁷

The basic monthly Part B premium increased from \$96.40 in 2009 to \$110.50 in 2010. However, the majority of beneficiaries who enrolled prior to 2010 were not affected by that increase, because there was no cost-of-living adjustment (COLA) to Social Security benefits for 2010 and a "hold-harmless" provision protects beneficiaries from a drop in their monthly net Social Security payment if an increase in the Part B premium exceeds the Social Security COLA. Since January 2007, higher income enrollees have faced greater premiums for Part B than other enrollees, but the basic premium of 25 percent still applies to about 95 percent of enrollees. The Patient Protection and Affordable Care Act (Public Law 111-148) froze the thresholds at which income-related premiums begin at the 2010 levels of \$85,000 for single beneficiaries and \$170,000 for couples through 2019. Thus, the share of enrollees that will be subject to income-related premiums will increase over time, owing to growth in beneficiaries' incomes.¹⁸

¹⁷ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

¹⁸ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

This option would gradually raise the basic Part B premium from 25 percent to 35 percent of the program's costs for enrollees ages 65 and older over a five-year period, beginning in 2012. The premium share would increase by 2 percentage points per year through 2016 and then remain at 35 percent, preserving the thresholds at which income-related premiums begin as specified in current law. Also, the hold-harmless provision would be preserved; that provision would apply to more enrollees in 2012 because of the initial increase in premiums under this option. The Congressional Budget Office projects that this option would result in estimated savings of about \$71 billion over the 2012–2016 period and about \$241 billion over the 2012–2021 period. Table 9 also includes a proposal recommended by the Domenici-Rivlin Task Force.

One rationale for this option is that it would ease the budgetary pressures posed by rising costs in the Part B program, which will climb faster as members of the baby boom generation reach age 65. Even under this option, the public subsidy for most Part B enrollees—65 percent when fully phased in—would be greater than the 50 percent that was intended at the program's outset. Also, because Medicaid pays the premiums for certain low income Part B enrollees with limited assets, about 18 percent of Medicare beneficiaries would be unaffected.¹⁹

Table 9: Ways to Increase the Basic Premium for Medicare Part B

PROPOSAL	Plan Description	10-year score
CBO Option	➤ Increase basic premium to 35 percent of the program's costs	-\$241.2 billion
Domenici-Rivlin Option	➤ Gradually raise Medicare Part B premiums from 25 percent to 35 percent of program costs over five years	-\$123 billion

Premium Support

Medicare has long vexed policymakers. For at its budgetary heart is an inherent conflict. It promises beneficiaries the finest medical sciences – at low or no cost. Then when budgetary costs get out of hand, Medicare fixes prices or stops covering services. Both lead to less access for seniors – violating the programs original pledge.

A simple solution would be switching Medicare to a defined contribution program – as proposed by the House. Seniors would be budgeted an annual contribution, which could be adjusted to reflect costs associated with their health status and financial wherewithal. For the federal budget, the result is a capped exposure to Medicare – one that would adjust to reflect the number of seniors and inflation but not unlimited desires.

¹⁹ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

That would be great news for the spending outlook. It would be even better news for the exploding debt and the threat it carries to the nation's economic health. But it would be better news yet for Medicare and its beneficiaries.

Medicare now presents participants with two problems: It is bad medicine, and it is unsustainable. It is bad medicine because its fragmented structure facilitates payments to hospitals (Part A), doctors (Part B) and drug companies (Part D) but does nothing to make sure that those parts coordinate to provide quality care.

This is a microcosm of the broader problems with U.S. health care. Seniors do have the options of signing up for a coordinated benefit – the so-called Medicare Advantage. But PPACA gutted that program to pay for its unwise entitlement expansion. Doing a u-turn on Medicare Advantage is one path to moving to a defined contribution system.

With a fixed amount of money in the market, providers would have the best economic incentives. It would provide benefits more cheaply and introduce efficiencies to permit adding more benefits. The latter means coordination, health information technologies, preventative services and a litany of other well-recognized needs.

Thank you. I look forward to answering your questions.



STATEMENT FOR THE RECORD

SUBMITTED TO THE

SENATE AGING COMMITTEE

ON

**A Time for Solutions: Finding Consensus in the Medicare
Reform Debate**

October 12, 2011

**AARP
601 E Street, N.W.
WASHINGTON, D. C. 20049**

For further information, contact:
Anna Schwamlein Howard
(202) 434-3770
Federal Health & Family Team
Government Affairs

On behalf of our members and all Americans age 50 and older, AARP appreciates the opportunity to submit comments on finding consensus in the Medicare reform debate. The Medicare program provides health security and a critical life-line for over 47 million Americans. AARP remains committed to ensuring the long-term viability of this critical health program.

AARP agrees with the need to tackle our nation's long-term fiscal challenges, and recognizes that going forward changes will have to be made to ensure our nation's long term fiscal health. However, we do not believe that Congress should use the current deficit debate to institute harmful cuts to benefits under the Medicare program.

Through surveys, town hall meetings, correspondence, and other forms of communication, we have heard older Americans' views on the nation's debt and its impact on programs that impact older Americans. Older Americans – regardless of their political party affiliation – overwhelmingly believe that fast-tracked health care cuts (including those to the Medicare program) should be “off the table” for deficit reduction.

Most Americans age 65+ live on limited, fixed incomes. The typical beneficiary today lives on an income of roughly \$20,000, and already struggles to pay for their ever-rising health and prescription drug costs. In fact, according to some estimates, nearly 20 percent of their income currently goes to health care costs. Others have estimated that nearly three quarters of Medicare beneficiaries live at or below 200 percent of the federal poverty level.

As individuals age, they tend to spend more on their health care – those 85 years and older spend \$7,710 a year out-of-pocket, on average, for their health care. Beneficiaries with cancer and other common medical conditions tend to carry higher out-of-pockets costs. The average out-of-pocket costs for an individual with Alzheimer's, for example, is about \$7,670 per year.

As Congress debates proposals to change the Medicare program, it is important to keep in mind that many beneficiaries lack the resources to shoulder additional cost-sharing. Older Americans have been hit hard by the economic downturn, and there is little time for them to recover and many -- particularly those who are already retired – have seen a diminution of their retirement assets, including the value of their 401(k) and other retirement savings plans. In addition, home prices across the country have fallen, thus decreasing the most valuable asset for most older Americans. At the same time, seniors already struggle to meet rising health care costs.

Therefore, AARP strongly urges Congress to reject any proposals that would impose arbitrary, harmful cuts to the Medicare program or shift additional costs onto Medicare beneficiaries. Such cost shifting undermines current and future beneficiaries' access to quality care; it does not rein in overall health care costs; and it fails to improve health care quality in the Medicare program for current and future beneficiaries.

AARP strongly opposes proposals that would increase the age of eligibility for Medicare from 65 to 67. Enacting this policy would increase cost-sharing for individuals who are not yet eligible for Medicare by an estimated over \$2,000 per year (many of whom currently lack access to affordable, comprehensive health insurance coverage); would increase Medicare premiums for everyone enrolled in the program; and would increase costs for employers who offer health insurance coverage.

Similarly, AARP opposes the addition of a home health copay or a copay in the first 20 days of skilled nursing facility (SNF) coverage because such proposals simply shifts costs onto Medicare beneficiaries. Medicare beneficiaries who may be subject to these copays are likely to be older, have more chronic conditions, be in poorer health, have lower incomes, and need help with daily activities, thus they already face higher costs than other Medicare beneficiaries.

Other proposals would impose additional premiums or taxes for beneficiaries who choose a low cost-sharing Medigap policy. Such proposals fail to take into account that many individuals choose these policies because they provide the beneficiary with certainty and health care security as well as the peace of mind to be able to financially manage a health care crisis or their ongoing health care needs. It is particularly important to keep in mind that applying any changes to current policyholders would unfairly impact beneficiaries who have planned their long-term health care needs.

Similarly, AARP opposes other proposals to simply shift costs onto beneficiaries and other payers that fail to address the root problems of rising health care costs throughout the health care system. For example, some proposals would require higher income Medicare beneficiaries -- defined as those with incomes of \$85,000 -- to pay more for their health care. These proposals fail to recognize that these individuals have already paid more into the Medicare program through payroll and income taxes, and are already subject to higher-income Part B and Part D premiums.

All health care costs, including Medicare costs, have been increasing at levels well above inflation each year. Medicare is but one part of our nation's health care system -- which includes other federal programs, private plans, state insurance plans, and individuals. Singling out the Medicare program -- either for arbitrary cuts or for increased costs to beneficiaries -- will not rein in overall health care costs. It will simply shift costs on to other payers of health care services, particularly beneficiaries and their families, and undermine current and future beneficiaries' access to quality care.

However, we do urge Congress to make changes to improve quality and the delivery of health care in the Medicare program. Earlier, this decade, Congress enacted legislation to add a much-needed prescription drug benefit to the program, benefits that allowed individuals to avoid worse health and more costly medical interventions. Recently, Congress enacted important delivery system reforms -- such as Accountable Care Organizations (ACOs), patient-centered medical homes, value-based purchasing, quality-based payments, and patient

safety initiatives. The best way to hold down costs in Medicare is to hold down costs throughout the health care system, with particular emphasis on delivery system reform. We have been working closely with providers, physicians, and health plans to help ensure that these delivery system reforms are implemented in such a manner that current and future beneficiaries benefit from both a higher quality and more efficient Medicare program.

Many health experts believe implementation of these significant delivery system reforms will take time, planning, and commitment from Congress, the Administration, and providers to help achieve a new way of delivering care: one that focuses on improving primary and coordinated care for beneficiaries, and payment incentives that reward quality and improved outcomes rather than volume. AARP believes that setting annual, arbitrary cost targets for Medicare will undercut this needed progress, and we strongly urge Congress not to enact such counterproductive measures.

Going forward, there are additional proposals that Congress can enact that would improve the Medicare program, without harming beneficiaries. The following provides only a few examples, particularly for high cost prescription drugs, of possible cost-saving ideas Congress should consider instead of simply asking older Americans to pay more for their care:

- *Prescription Drug Rebates for Duals:* AARP supports legislation (S. 1206) that would require prescription drug manufacturers to provide rebates for drugs provided to Medicare Part D low-income subsidy beneficiaries, including those who are dually eligible for Medicare and Medicaid. This legislation is expected to save the Medicare program over \$100 billion over the next ten years without negatively impacting Medicare Part D benefits.
- *Biologic Exclusivity:* AARP supports reducing the exclusivity period for biologic drugs. While the Affordable Care Act created a pathway for the FDA approval of generic versions of biologic drugs, or biosimilars, the period of exclusivity for their brand-name counterparts is currently twelve years. AARP and many others, including the Federal Trade Commission, have long stated that this period of exclusivity is excessive and serves to over-compensate brand-named pharmaceutical companies while keeping much-needed biosimilar drugs from coming to market. As more research and development is conducted in the biologic marketplace, improving upon the pathway is vital.
- *Prohibit Pay-For-Delay Agreements:* AARP supports legislation (S. 27) that will help to bring lower cost generic drugs to market sooner by preventing abuses in patent settlements between generic and brand prescription drug companies. When brand and generic drug manufacturers wrongly conspire to delay market entry of a generic drug, consumers, health plans, and taxpayers are forced to continue to pay for the higher cost brand name drug for a longer period of time.

- *Medicare Secretarial Negotiating Authority*: AARP supports legislation that builds upon the strong foundation of the Medicare prescription drug law by enabling the Secretary of HHS to use the bargaining power of Medicare's 47 million beneficiaries to negotiate for lower prescription drug prices.
- *Prescription Drug Reimportation*: AARP supports the Pharmaceutical Market Access and Drug Safety Act (S. 319), sponsored by Senators Stabenow and Snowe, which would establish a framework for the safe, legal importation of lower-priced prescription drugs from abroad.
- *Medicare and Medicaid FAST Act*: AARP supports legislation (S. 1251), introduced by Senators Carper and Coburn, which seeks to curb waste and fraud from the Medicare and Medicaid programs. Eliminating fraud from the Medicare and Medicaid programs means greater assurance that taxpayer and beneficiary money will go towards providing health care services.
- *Medicare Common Access Card Act*: AARP supports legislation (S. 1551), introduced by Senators Kirk and Wyden, which will create a secure card pilot program under the Medicare program.

As this Committee – and all of Congress – work to reform the Medicare program, it is imperative that Congress address the Medicare reimbursement of physician services. Unless Congress acts by the end of the year, physicians and other clinicians (such as nurse practitioners) who treat Medicare beneficiaries will see their payment rates reduced by nearly 30 percent. Facing this constant uncertainty and dramatic cuts to their payments, there is growing concern that more and more physicians will choose to no longer take Medicare patients, which impacts beneficiaries' access to care. AARP strongly urges all Members of Congress to come together to enact the longest possible resolution to the SGR problem.

CONCLUSION

On behalf of our millions of members and all older Americans, we thank you for the opportunity to share with you our views on finding consensus in the Medicare reform debate. As Congress continues its work to rein in federal spending, we strongly urge you to enact legislation that will strengthen the vital Medicare program without harmful cuts or added costs to beneficiaries, and without arbitrary, across the board cuts that may harm Medicare.

ACCESS TO MEDICAL IMAGING COALITION

October 26, 2011

Senator Herb Kohl
Chairman
U.S. Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, DC 20510

Senator Bob Corker
Ranking Member
U.S. Senate Special Committee on Aging
628 Hart Senate Office Building
Washington, DC 20510

**Re: Statement for the Hearing Record
“A Time for Solutions: Finding Consensus in the Medicare Reform Debate”
October 12, 2011**

Dear Chairman Kohl and Ranking Member Corker:

On behalf of the Access to Medical Imaging Coalition (AMIC), I am writing to express our members' serious concerns about the comments related to medical imaging utilization made by Senator McCaskill during the Aging Committee's October 12th hearing on Medicare reform, and to correct specific factual inaccuracies included in her comments.

During the hearing, Senator McCaskill recalled a meeting with a group of physicians that she attended during health reform in which she asked the physicians how often they use their imaging equipment. She stated, “The least any of them were utilizing their machines was 92 percent, and of course the Medicare reimbursement is dependent on an assumption that they're only using them about 50 percent of the time.” From this conversation, the Senator generalized that physicians are systematically overutilizing medical imaging equipment in order to profit from the Medicare program. She therefore suggested that increasing the utilization rate assumption is an area where members can “find consensus.”

Our members are extremely troubled by the Senator's comments, which (1) misstate the actual utilization rate assumption that applies to medical imaging equipment, (2) equate frequent use of imaging equipment to overutilization, and (3) generalize the experience of a few physicians to the totality of the physicians who participate in the Medicare program.

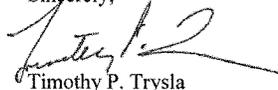
First, the utilization rate assumption for most advanced imaging equipment is **currently 75 percent** and has not been at 50 percent since 2009. The Centers for Medicare & Medicaid Services (CMS) began phasing in a higher utilization rate assumption in 2010, and the Affordable Care Act set the rate at 75 percent beginning in 2011. Second, the rate at which imaging equipment is used by physicians to diagnose and treat seniors varies significantly depending upon numerous factors, such as the types of conditions they are treating, specialty and practice setting. “Overutilization” signifies that inappropriate use of imaging is occurring—that more services are being performed than are needed to diagnose and treat patients. That one particular physician office uses an imaging machine 92 percent of the time it is open *does not* in itself indicate that overutilization is occurring or that any of the services were performed inappropriately. Furthermore, the most recent and comprehensive data on imaging equipment utilization, based on a 2010 survey by AMIC and the Radiology Business Management Association, showed that **utilization rates of advanced imaging equipment are actually closer to the previous Medicare assumption of 50 percent** (see attached Executive Summary).

Finally, our members take issue with the Senator's conclusion—based on her incorrect presumption that a high rate of utilization equates to overutilization—that physicians are taking advantage of the Medicare program and that therefore increasing the utilization rate should be an easy place to find consensus. Numerous times over the last 6 years, Medicare reimbursements for imaging services for seniors have been cut in order to pay for other policies under the guise of achieving “appropriate” payment rates. Apart from short-term sustainable growth rate (SGR) patches, there has not been a major Medicare bill or a Physician Fee Schedule rule since 2006 that did not propose a substantial cut to medical imaging payments or other major policy changes. In particular, the imaging accreditation program and the appropriateness demonstration established under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) were intended to ensure appropriate use of imaging through clinically-based and quality-focused methods, rather than further draconian cuts. These programs are now being implemented by CMS and have not yet had an opportunity to show their effectiveness.

The medical specialties represented by AMIC—radiology, cardiology and oncology—depend on medical imaging technologies to diagnose and treat our seniors' most devastating diseases, including heart disease and breast, lung, prostate and other cancers. *Further* reducing Medicare reimbursement levels for advanced imaging services would make it financially very difficult for physicians to continue offering these services in the community, which would jeopardize seniors' access to care. The potential impact is not limited to advanced imaging—the closing of imaging centers in the community would mean that standard imaging modalities like x-ray, mammography and ultrasound would also not be available. While all modalities would likely still be available in hospitals (which, for those in rural areas of the country, could be hundreds of miles away), access would be restricted by long waiting times for appointments, appointments at odd hours of the day, and long lines in the waiting room.

As Congress considers further changes to the Medicare program, we request your assistance in protecting seniors' access to life-saving diagnostic imaging services—the right scan at the right time. We appreciate this opportunity to correct the hearing record and would be pleased to answer any questions you may have.

Sincerely,



Timothy P. Trysla
Executive Director

cc: Senator Ron Wyden	Senator Susan Collins
Senator Bill Nelson	Senator Orrin Hatch
Senator Bob Casey	Senator Mark Kirk, III
Senator Claire McCaskill	Senator Dean Heller
Senator Sheldon Whitehouse	Senator Jerry Moran
Senator Mark Udall	Senator Ronald Johnson
Senator Michael Bennet	Senator Richard Shelby
Senator Kirsten Gillibrand	Senator Lindsey Graham
Senator Joe Manchin, III	Senator Saxby Chambliss
Senator Richard Blumenthal	

2010 AMIC Imaging Equipment Utilization Survey Executive Summary

In 2009 the Radiology Business Management Association (RBMA) conducted an imaging equipment utilization rate survey that found usage rates much closer to Medicare's previous assumption of 50 percent and much lower rates for advanced imaging (e.g., CT, MR) than those recommended by legislators and policy makers. RBMA found that imaging equipment in rural regions of the country operates 48 percent of the time an office is open for business, while equipment in non-rural areas operates 56 percent of the time a center is open for business. The RBMA data, consisting of 261 imaging machines in 46 centers, showed and used the current Medicare assumption.

While RBMA's 2009 survey provided data showing actual utilization rates are lower than both the 90 percent use rate recommended by MedPAC and the 75 percent rate mandated by the Affordable Care Act, the sample size used fell short of a definitive study. To create a larger cohort of respondents, the Access to Medical Imaging Coalition (AMIC) collaborated with RBMA to replicate the survey with an expanded number of participants.

Methodology

General

The AMIC Equipment Utilization Survey (EUS) questionnaire was developed using the 2009 RBMA EUS questionnaire as the base and with input from the Data Committee of AMIC. AMIC contracted with Sage Computing to conduct the survey and analyze the results. The survey collected information on imaging center characteristics and equipment utilization by major imaging machine/modality (with data collected on elements of the Medicare formula used to calculate equipment cost per minute).

Web-based surveys were first piloted using members selected by RBMA, the Cardiology Advocacy Alliance (CAA), and the Association for Quality Imaging (AQI). The respondents had three options to complete the survey:

1. Complete it online
2. Download the paper version and mail/fax back to Sage Computing
3. Upload data files into the system

The web-based survey had links to an FAQ section where the respondents were provided instructions on how to respond to the particular question. In addition, support was provided to respondents via email and telephone.

The pilot test e-mail was sent to 20 facilities (6 members from AQI, 5 from CAA, and 9 from RBMA) on January 25, 2010. Responses were due by February 1, 2010. In addition to the initial email sent by Sage, each of the three participating organizations also sent emails to the members included in the pilot test. During the pre-test it was found that one of the AQI members was not eligible to participate as they did not do any provider-based billing. In addition, there were two members from AQI and RBMA who were identified by both organizations. Pilot test members were asked to provide feedback on specific questions which were either ambiguous or hard to respond to, and the data was analyzed for consistency. A total of 7 member responses were received covering 14 facilities.

The pre-test results were discussed with the AMIC Data Committee on February 3, 2010, via conference call. And the survey questionnaire was modified based on the responses from the pilot test.

A combined list of 1,106 members was created from the lists supplied by RBMA, AQI, and CAA. The list did not include duplicates (members who belonged to more than one organization) so they only received one invitation. Members whose e-mail addresses were not known were also removed from the list. The final list included 786 names from RBMA, 259 from CAA, and 61 from AQI. All three associations sent a pre-survey letter to the members letting them know about the upcoming survey and asking them to participate. In addition, AQI arranged a conference call for all members along with representatives from Sage and RBMA to respond to member queries regarding the survey. An invitation to participate in the survey, along with a link to the questionnaire, was e-mailed on February 12, 2010. There were several reminder e-mails sent by Sage and the three participating organizations to increase the number of responses. The following table summarizes the survey timeline.

Pre-survey notification letter e-mailed to members of RBMA, AQI, and CAA	Last week of January
AQI Member Conference call with all members	February 5, 2010
Survey invitation e-mailed	February 12, 2010
First reminder notice from Sage	February 18, 2010
Second reminder email from Sage	February 24, 2010
Third reminder email from Sage	March 1, 2010
Fourth reminder email from Sage	March 4, 2010
Survey close-out	March 9, 2010

A total of 720 surveys were submitted by 196 members for a response rate of 18 percent. A total of 74 responses (170 facilities) were received from RBMA, 76 responses (147 facilities) from CAA, and 31 responses (357 facilities) from AQI. For an additional 15 responses (46 facilities) the membership affiliation could not be determined. In total, these respondents provided data on 2,843 machines.

Modalities

The survey collected information for each of the major diagnostic imaging modalities: MR, CT, PET, PET-CT, General Radiology (GR), Dual Energy X-ray Absorptiometry (DEXA), Ultrasound (U/S), Mammography (Mammo), and Nuclear Medicine (NM). Radiation oncology and Interventional Radiology modalities were excluded. In this report, advanced imaging is defined as CT, MRI, PET, PET/CT, and nuclear medicine.

Rural vs. Non-Rural

The questionnaire collected each respondent's zip code, which was used to determine rural and non-rural status. This status was based on the CMS Rural Health Programs definition of "rural" as being outside a Census-defined Urbanized Area. The CMS data file was downloaded and the zip code of the respondent was matched against those in the file to determine their location. In addition, respondents were asked to classify themselves as "rural" or "non-rural." In almost all cases, the self classification matched the classification based on CMS database.

Data Cleaning

In reviewing the submitted information, a limited number of respondents' data exhibited internal inconsistencies in the depiction of equipment time. Sage staff contacted the respondents via e-mail and telephone to obtain clarifications where the data was inconsistent. For most cases the inconsistencies were resolved. However, there were few responses where the individual completing the survey could not be reached. These responses were not included in the analysis.

Equipment Utilization Rate

Utilization rate data components were cleaned by eliminating records for which the sum of weekly minutes in use and weekly minutes available but not used did not approximate the total number of weekly minutes available. Two utilization rates were calculated: (1) an availability-based rate (weekly minutes used ÷ weekly minutes available) and (2) the current Medicare-based utilization rate (weekly minutes used ÷ 3,000 [50 hours per week * 60 minutes per hour]). The rates were calculated for all machines by modality, for advanced vs. non-advanced modalities, and for non-rural vs. rural centers.

- Availability-based = machine time used in patient care/machine time available
- Medicare formula (non-CT/MR) = machine time used in patient care*50 weeks/150,000 minutes
- Medicare formula (CT and MR) = machine time used in patient care*52 weeks/156,000 minutes

Results

- Overall utilization rates are lower than RBMA's 2009 survey; new rates are closer to CMS' original 50 percent usage rate

2010 IEUS

	N	Lower Quartile	Mean	Median	Upper Quartile
Availability-based Utilization Rate	2843	40%	58%	60%	77%
Medicare-based Utilization Rate	2703	28%	47%	48%	66%

2009 IEUS

	N	Lower Quartile	Mean	Median	Upper Quartile
Availability-based Utilization Rate	282	46%	65%	68%	90%
Medicare-based Utilization Rate	262	38%	53%	54%	72%

- Rural centers continued to exhibit lower utilization rates than non-rural centers overall (statistically significant)

2010 IEUS

		All	Nonrural	Rural
Availability-Based Utilization Rate	N	2841	2611	230
	Q1	40%	41%	33%
	Mean	58%	58%	50%
	Median	60%	60%	52%
	Q3	77%	78%	67%
Medicare-based Utilization Rate	N	2701	2480	221
	Q1	28%	29%	16%
	Mean	47%	48%	38%
	Median	48%	49%	34%
	Q3	66%	66%	56%

2009 IEUS

		All	Nonrural	Rural
Availability-based Utilization Rate	N	281	233	48
	Min	0%	0%	1%
	Q1	46%	49%	30%
	Mean	65%	67%	57%
	Median	68%	71%	58%
	Q3	90%	90%	85%
	Max	100%	100%	100%
Medicare-based Utilization Rate	N	261	217	44
	Min	0%	0%	1%
	Q1	38%	43%	22%
	Mean	53%	55%	43%
	Median	54%	56%	48%
	Q3	72%	72%	64%
	Max	99%	99%	88%

- Usage rates for advanced imaging, specifically for MR and CT, are lower than RBMA's 2009 survey.

2010 IEUS

			MR	CT	Advanced imaging	Not advanced imaging
Availability-based Utilization Rate	N	2843	522	301	1215	1628
	Q1	40%	50%	28%	41%	39%
	Mean	58%	63%	47%	57%	58%
	Median	60%	64%	46%	59%	60%
	Q3	77%	78%	66%	75%	78%
Medicare-based Utilization Rate	N	2703	427	295	1113	1590
	Q1	28%	38%	22%	27%	29%
	Mean	47%	57%	41%	47%	47%
	Median	48%	60%	38%	45%	49%
	Q3	66%	73%	59%	66%	66%

2009 IEUS

			MR	CT	Advanced imaging	Not advanced imaging
Availability-based Utilization Rate	N	282	47	30	100	182
	Q1	46%	62%	31%	56%	43%
	Mean	65%	73%	62%	70%	62%
	Median	68%	76%	59%	75%	64%
	Q3	90%	90%	90%	90%	90%
Medicare-based Utilization Rate	N	262	35	29	85	177
	Q1	38%	50%	30%	47%	33%
	Mean	53%	64%	56%	61%	49%
	Median	54%	72%	50%	63%	50%
	Q3	72%	80%	79%	79%	72%

- Hours an office is open per week are lower than RBMA's 2009 survey (50-53 hours vs. 55 hours)

	2010 IEUS	2009 IEUS
Lower Quartile	40	43.0
Mean	52.82	55.4
Median	50	55
Upper Quartile	60	62.5

