Hearing on Preserving and Strengthening Medicare

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CONTENTS

WITNESSES

PRESERVING AND STRENGTHENING MEDICARE

Wednesday, March 16, 2016

House of Representatives,

Subcommittee on Health,

Committee on Ways and Means,

Washington, D.C.

The subcommittee met, pursuant to notice, at 10:02 a.m. in Room 1100 Longworth House Office Building, Hon. Pat Tiberi [chairman of the subcommittee] presiding.

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

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

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 Obamacare's raid on the program and the increased regulatory burden on providers piled on to the outdated structure of traditional Medicare benefit is causing today's seniors to be inundated with an array of confusing deductibles, coinsurance, co-payments with no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

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

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

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

Updating the Medicare benefit design will bring the program into the 21st Century and meet the needs of current and future seniors. These reforms would bring the traditional fee-for-service benefit up to the standards that 17 million people, nearly 32 percent of enrolled seniors, are currently enjoying under the Medicare Advantage program. MA plans offer high quality, coordinated care for our seniors. These plans also provide stability: largely stable co-payments; financial protections provided by maximum out-of-pocket limits; and strong incentives under their benefit structures to encourage seniors to receive the most high value, efficient care possible.

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

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

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

*Chairman Tiberi. So, with that, I would like to recognize the gentleman from the great northwestern state of Washington, the distinguished ranking member, Dr. McDermott.

*Mr. McDermott. Wow.

[Laughter.]

*Chairman Tiberi. We are bipartisan.

*Mr. McDermott. Well, in that spirit, I want to indicate that one member of the committee is inching toward being on Medicare. This is Mr. Kind's birthday.

*Chairman Tiberi. This is your birthday song.

[Laughter.]

*Mr. Kind. Thank you. Thanks, Doc. I feel good.

*Mr. McDermott. Keep feeling good. I must start with an apology. I have to leave this hearing after I make my opening statement, because in the wisdom of the leadership of this House, they had two hearings coherent -- or congruently meeting: this Committee, which is supposed to be preparing and

preserving -- preserving and strengthening Medicare; and the Budget Committee, which is about to write a budget to unwind Medicare as we know it. At the very same time.

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

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

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

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

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

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

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

We continue to overpay the insurance industry through the Medicare Advantage program. Although ACA reduced these overpayments by 156 billion, we have a lot of work to crack down on widespread upcoding and cherry-picking of beneficiaries. And this Committee still has put no effort into scrutinizing the recent insurance industry consolidation, which is unprecedented in scale and threatens to eliminate competition in the Medicare Advantage program.

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

*Chairman Tiberi. Oh, no worries on my part.

*Mr. McDermott. And stop you from succeeding.

[Laughter.]

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

*Mr. McDermott. You should tell him I am on my way.

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

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

First, Katherine Baicker, the C. Boyden Gray Professor of Health Economics, and chair of the department of health policy and management at Harvard University's T.H. Chan School of Public Health is with us.

Next we will hear from Bob Moffit, a senior fellow at the Heritage Foundation.

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

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

Ladies first, Ms. Baicker.

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

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

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

And I think there are three ways that the Medicare Advantage program can do this. The first is managing the quantity of care the beneficiaries get. There is a lot of evidence that there is care delivered to beneficiaries that is, at best, minimally helpful to their health and, at worst, actually harms their

health. And reforming the fee-for-service program to try to reduce that wasteful care that is not helping anyone and costing the system billions of dollars, that needs to be an ongoing effort.

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

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

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

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

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

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

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

We need better quality information, both for beneficiaries and to underpin incentives for proprietors to deliver high-quality care. No one wants stinting on care in these programs, and quality measures help guard against that.

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

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

*Chairman Tiberi. Thank you, Dr. Baicker.

Mr. Moffit, you are recognized for five minutes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much, Mr. Chairman.

That concludes my remarks.

*Chairman Tiberi. Thank you, Mr. Moffit.

Mr. Guterman, you may proceed. You have five minutes.

STATEMENT OF STUART GUTERMAN, SENIOR SCHOLAR IN RESIDENCE, ACADEMYHEALTH

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

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

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

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

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

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

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

Still, policy-makers are confronted, especially with the slow growth in per-beneficiary spending, on how to control the growth of Medicare spending. But I do suggest that there is also a revenue side that, as has been mentioned, is projected not to increase over the years, even as the proportion of Medicare beneficiaries grows.

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

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

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

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

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

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

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

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

*Chairman Tiberi. Thank you.

*Mr. Guterman. -- private plan, so that they can --

*Chairman Tiberi. Thank you, Mr. Guterman.

*Mr. Guterman. -- provide an appropriate counterpoint.

*Chairman Tiberi. Thank you.

*Mr. Guterman. Thank you

*Chairman Tiberi. You are one minute over. I gave you a little bit more time.

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

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

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

*Chairman Tiberi. No, you are good.

[Laughter.]

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

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

And we have seen better experimentation in MA plans with getting people out of the hospital and home and healthier faster. So freeing up that flexibility that they have, I would think, would be of first-order

importance. Ensuring that quality information is available to the beneficiaries, but then plans are rewarded appropriately for providing high-quality care.

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

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

*Chairman Tiberi. Great, thank you.

Dr. Moffit, a question for you that pertains to protecting beneficiaries in the Medicare program. As mentioned, there is no out-of-pocket cap in traditional Medicare, yet the MA program is required to offer that type of protection to beneficiaries. A central feature of the bipartisan options to combine Medicare Parts A and B, as has been mentioned, includes that necessary protection.

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

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

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

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

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

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

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

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

*Chairman Tiberi. Thank you. I am going to turn to Mr. Thompson. But before I do that, you were all nodding, I think, yes when he talked about MediGap reform. All agree? Okay, interesting. Maybe we can all agree up here, too.

Mr. Thompson, you are recognized for five minutes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Mr. Guterman. Well --

*Mr. Thompson. -- are those protections --

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

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

*Mr. Guterman. How would --

*Mr. Thompson. How would sicker patients fare?

*Mr. Guterman. Sicker patients fare. Well, you know --

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

*Mr. Guterman. -- sicker patients are the ones that are least attractive to private health insurance companies. And there has been, over the years, some concern about private plans in what is now Medicare Advantage tending to sign up healthier patients.

*Mr. Thompson. Thank you.

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

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

Mr. Johnson is recognized for five minutes.

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

Despite critics' claims, studies have found that physician-owned hospitals do not decrease self-referrals and services [sic]. The truth is that hospital consolidations are driving up the cost. And that is happening without increased services or better care. Even the Federal Trade Commission has recognized the critical role private-owned hospitals play in promoting competition, reducing costs, and increasing quality. Yet this anti-competitive policy remains in place, and that is just wrong. Medicare beneficiaries deserve better.

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

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

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

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

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

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

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

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

*Mr. Johnson. Thank you, sir. I appreciate that. And my time is about gone. But Dr. Baicker, would you try to let us know later, what the system is doing as far as Obamacare is concerned? I am concerned that our cuts are phased in along with CMS, continuing to hinder plan innovation by over-regulation. And

that result will be more and more of these plans leaving the market and forcing beneficiaries back into fee-for-service. If you agree -- you are shaking your head yes.

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

*Chairman Tiberi. Thank you, Mr. Johnson.

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

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

*Mr. Kind. No, I don't, but --

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

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

*Mr. Kind. Good, I am glad.

[Laughter.]

*Chairman Tiberi. So happy birthday, and you are recognized for five minutes --

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

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

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

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

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

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

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

announced here that 30 percent of Medicare payments will be quality-based, and their goal is to be 50 percent next year and over 80 percent over the next few years.

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

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

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

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

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

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

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

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

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

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

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

*Chairman Tiberi. Mr. Guterman, I need you to wrap it up real quick here.

*Mr. Guterman. Okay.

*Chairman Tiberi. You are over.

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

*Mr. Kind. Thank you.

*Chairman Tiberi. Thank you.

Mr. Buchanan, recognized for five minutes.

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

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

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

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

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

So, when you take a look at this, there has to be some kind of a structural change or something at some point on a bipartisan level. Otherwise, we are kidding ourself [sic]. I mean we could look around the edges and do a few things here and there, but we have got to do something material.

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

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

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

*Mr. Moffit. Well, I do think that --

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

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

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

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

*Mr. Buchanan. But what is your recommended structural change --

*Mr. Moffit. My recommended structural --

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

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

Secondly, I think that we ought to expand means testing in Medicare. The President himself has recently come out with a proposal. His budget proposal would require upper income seniors to pay more, going forward. And eventually, under the President's proposal, 25 percent of all seniors would be paying above the existing standard rate. I don't think we have to go to 25 --

*Mr. Buchanan. And your third point is what?

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

*Mr. Buchanan. Thank you. I will have to yield back.

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

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

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

*Mr. Guterman. That, of course, is a very controversial issue. I think --

*Mr. Lewis. Well, we need -- maybe we need a little controversy this --

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

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

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

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

*Mr. Guterman. Well, I think --

*Mr. Lewis. More of us are living much longer because their healthcare --

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

*Mr. Lewis. No, it's not.

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

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

*Mr. Guterman. Right. Yes. CMS has been doing a whole range of things to try to figure out how to better coordinate care. A number of the policies that are being developed by the Center for Medicare and Medicaid Innovation are addressing that issue. And, in fact, CMS has been working on that issue for

years. When I was in CMS during the Bush administration, we developed many chronic care initiatives that have since been refined over time and hopefully will end up finding the most effective ways to deal with our elderly population.

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

*Mr. Lewis. Other witness like to respond?

*Mr. Guterman. I'm sorry?

*Mr. Lewis. Dr. Baicker, Dr. Moffit.

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

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

*Mr. Lewis. Thank you. I yield back.

*Chairman Tiberi. Thank you, Mr. Lewis.

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

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

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

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

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

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

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

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

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

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

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

*Mr. Jenkins. Alrighty. Thank you. Mr. Chairman, I yield back.

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

*Mr. Paulsen. Thank you, Mr. Chairman. It's great to have you as the chair of the Committee, and I'm happy to be on this health subcommittee now.

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

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

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

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

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

I would just simply add that with regard to the Medicare Advantage program, which is, in fact, a defined contribution type of program, private plans competing against one another, have actually pioneered in many respects the kinds of delivery reforms that have proven -- that have become very popular more recently. These are things like care coordination and case management and a heavy emphasis on preventive care.

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

*Mr. Paulsen. Ms. Baicker, real short, and then I'm going to ask a follow-up question real quick.

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

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

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

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

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

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

But the fact of the matter is there is nothing comparable to that being proposed by any Member of Congress that I am aware of, Republican or Democrat, or has been proposed for the past 20-some years where this issue has been discussed, which is actually talking about a voucher system. We're talking about a defined contribution, and most all of our federal employees are involved --

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

Mr. Blumenauer is recognized for five minutes.

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

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

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

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

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

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

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

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

But I think before we wade into things that the topline people will battle over, we can do that. But there's lots of consensus I think here for things, expanding the pilots, modifying the benefits, looking where value really exists and being able to build on some of the bipartisan interest that we've had on this Committee and elsewhere to be able to deal with it. Because, yes, we're going to probably need more revenue when we have tens of millions more senior citizens.

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

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

*Chairman Tiberi. Thank you. That's great.

The gentleman from Texas is recognized for five minutes.

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

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

*Chairman Tiberi. Brave man.

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

*Ms. Baicker. I didn't watch those commercials.

*Mr. Marchant. Yeah?

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

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

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

*Mr. Guterman. Yeah, I --

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

*Mr. Guterman. Thank you. Living in the Washington area, I'm very familiar with those commercials, and also being on the verge of becoming a Medicare beneficiary myself, I'm also familiar with the vast amount of mail that I get on Medicare Advantage.

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

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

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

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

*Mr. Marchant. Okay. Mr. Moffit?

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

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

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

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

So my plea would be for the Congressional budget office or the general governmental accountability office or somebody to actually look and find out how much Medicare Advantage is actually saving the taxpayers -- by making it an alternative to the traditional Medigap program. Maybe Dr. Guterman doesn't

agree with me on this, but I think frankly there's nothing wrong with looking under the hood and finding out.

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

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

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

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

Ms. Baicker, go ahead.

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

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

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

*Mr. Smith. Okay. Mr. Moffit?

*Mr. Moffit. (Off-mic.)

*Mr. Smith. If you could, turn on your mic.

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

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

*Mr. Moffit. Joining a plan and participating in the process?

*Mr. Smith. Has the penalty been effective --

*Mr. Moffit. Oh.

*Mr. Smith. -- in encouraging people to join the plan?

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

*Mr. Smith. Okay. And perhaps for reflection later because time is limited --

*Mr. Moffit. Sure.

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

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

*Mr. Smith. Okay. Mr. Guterman.

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

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

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

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

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

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

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

*Mr. Smith. Thank you, Mr. Chairman.

*Chairman Tiberi. Thank you, Mr. Smith.

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

*Mrs. Black. Thank you, Mr. Chairman. I --

*Chairman Tiberi. You're recognized for five minutes.

*Mrs. Black. -- want to congratulate you for being the chairman of this Committee. I know you well enough to know that you're going to study all of these issues and know them inside and out. So you're going to make a great chairman of this Committee. And the reason why you don't see Congressman McDermott is we have him tied up in the chair there in the budget hearing.

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

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

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

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

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

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

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

Maybe for the low-risk patient, the copayment should be 10 or $20. That kind of innovation is not about shifting costs onto the patient who's paying the higher copay, but rather shifting use of the statin towards the patient with the highest health benefit for it. So I'm very much in favor of exploring that, and there's some nods to that in existence already. There's some experimentation in the Medicare Advantage program itself now with value-based insurance design. Safe harbors for preventive care are an example of value-based insurance design, where when you go to get a preventive care treatment that is of sufficiently

high value, you don't have to pay copayments even if you're in a high-deductible plan. So I think those are very much worth exploring.

*Mrs. Black. Does anyone else have a comment on that? Mr. Guterman?

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

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

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

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

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

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

So I do take issue with something you said with respect to Medicare Advantage, and that is that Medicare Advantage plans are paid more. Some are paid more, but my understanding is they're paid more because of quality bonuses that they receive, and I mentioned about that Catholic plan in my district that has very high marks and spoken to many of their beneficiaries over the years.

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

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

And as I think Dr. Moffit pointed out, when opponents of trying to expand seniors' choice say "voucher" to think about how these awful systems are going to take place to leave seniors abandoned, I don't think that's a really good way to try to come together to figure out how we best serve patients, seniors, in a more

cost-effective, value-added, comprehensive way when we know that the current system based upon CBO's recent report is heading toward the brink of redness. So let's talk about that, and I would like you to first talk about that because I believe you're sincere in what you believe, and then hear from Dr. Moffit and Dr. Baicker. Dr. Guterman.

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

*Chairman Tiberi. Love to have your suggestions on that.

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

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

So I think that Medicare Advantage does have a tremendous amount of promise to improve Medicare across the board. I think we need to do a better job of paying them appropriately and rewarding the kind of performance we want from plans.

*Chairman Tiberi. That's fair.

Dr. Moffit.

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

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

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

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

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

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

There is a professor from Emory University, Professor Zhou Yang, who has suggested that we take the existing premiums or the premium support notion and at least create a defined contribution experiment where we actually adjust the payment going on a per capital basis to patients on their behavior, their willingness to enroll in preventive and wellness programs. There are a multitude of things that we can do that we are not doing.

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

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

*Chairman Tiberi. Thank you.

Dr. Baicker, thoughts?

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

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

*Chairman Tiberi. Dr. Guterman, in response?

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

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

*Chairman Tiberi. Add-ons.

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

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

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

*Chairman Tiberi. It's all Scully's fault.

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

*Chairman Tiberi. So we'd all agree, that transparency is desperately needed? Any other thoughts?

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

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

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

But what was the effect of the transparency. The effect of it was tremendous because when the commission staff went back, just about everybody had improved their performance. Some institutions decided that, frankly, measuring up to the standards was a little too much and they gave up that particular

cardiac program. But others actually improved. And that's how you get real change. There's nothing like sunlight, and it applies especially to Medicare.

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

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

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

Member Questions For The Record

Public Submissions For The Record