Hearing on the President's and Other Bipartisan Proposals to Reform Medicare

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C O N T E N T S

WITNESSES

Mr. Joesph R. Antos, Ph.D.
Wislon H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute

Witness Statement [PDF]

Mr. Joe Baker
President, Medicare Rights Center

Witness Statement [PDF]

Ms. Alice M. Rivlin, Ph.D.

Witness Statement [PDF]

Hearing on the President's and Other Bipartisan Proposals to Reform Medicare

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:03 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding. Advisory

Chairman Brady. Subcommittee will come to order. I want to welcome everyone to today's hearing on the President's budget and other bipartisan proposals to reform Medicare. This is the fourth hearing for our subcommittee this Congress, and the second Ways and Means Committee hearing in a series focused on proposals to reform Medicare and Social Security. During our first hearing of Congress we focused on redesigning the Medicare benefit package to make it more rational, more responsive to seniors and Medicare patients. Today's discussion is an extension of that hearing discussing the details around these three specific policies:

One, increasing income-related premiums for Medicare Parts B and D; two, increasing annual Medicare Part B deductibles, and three, establishing a home health copay. We focused on these three policies because they are included in the President's 2014 budget and supported by several bipartisan organizations. All too often recently, discussions surrounding finding Medicare savings have come under the context of a "grand bargain" or a "super committee." As the committee of jurisdiction over these critical topics, we have an obligation to discuss them publicly and determine how best to craft policy in these areas. That is why we are holding this hearing today.

The President's budget estimates that these three policies will save $54 billion over 10 years. These are real savings for a program that is facing bankruptcy in 10 short years. Asking seniors to pay more when they have the means to do so is not a new concept. In 2003, Republicans led the charge with income-related premiums for Medicare Part B in the Medicare Modernization Act, which ensured that seniors have access to accessible, affordable, high-quality medicines through free market competition for their business.

In 2010, Democrats included income-related premiums in the Medicaid program, Health Exchanges, and increases for Medicare Part D in the Affordable Care Act, known as ObamaCare. Throughout Federal programs, there has been recognition that some seniors can contribute more and some seniors need additional assistance. The growth of the retiree population has been and will continue to be a tremendous source of stress on Medicare's finances.

When Medicare was enacted in 1965, the average life expectancy was 70.2 years. It was anticipated that Medicare would cover an average person's health expenditures for the last 5.2 years of their life. In 2010, the average American lived to the age of 78.4, which means Medicare covered the last 13.5 years of life, a

158 percent increase. Yet, we have not made changes to the Medicare benefit structure to address this increase.

Now, I know that some may want to reject these policies out of hand and may suggest that the overall Medicare spending for seniors has decreased. They may contend that this means there is less of a need to find Medicare savings. But I, too, am glad to see Medicare spending is down, but the program is headed toward bankruptcy in 10 short years. Burying our heads in the sand and waiting for the looming crisis to overwhelm us will only force future Congresses to take more drastic measures.

Even the Medicare trustees recognize the growing challenges of Medicare's financial future as the baby boomers enter Medicare. Even if per-senior spending decreases, that will not help the sustainability of the trust fund when the number of new seniors coming into the program begins to dramatically increase.

And simply cutting providers is not the answer. In fact, the Medicare trustees warn because of cuts already in law, 15 percent of our Part A providers will be unprofitable by the end of this decade. Roughly 40 percent would be unprofitable by 2050. The actuaries warn that these cuts will force providers to withdraw from providing services to our Medicare seniors and patients.

Finally, instead of simply focusing on how much money a policy might save Medicare or how many more beneficiaries will pay more, I challenge this committee and our witnesses today to think differently. The question we should be asking ourselves is, how can we act now, this year, to extend Medicare solvency? If not permanently, how about for an additional 10 years beyond 2023? Why not extend its life an additional 20 years? We owe it to current and future seniors to examine and pursue these critical goals. It will require hard decisions, yes. But making them now will ensure a vibrant Medicare for generations to come.

Before I recognize Ranking Member McDermott for the purposes of an opening statement, I ask unanimous consent that all Members' written statements be included in the record. Without objection, so ordered.

Chairman Brady. I now recognize Ranking Member McDermott for his opening statement.

Mr. McDermott. Thank you, Mr. Chairman.

There was a time in the Congress when the procedure was that the President proposed and the Congress disposed. And so I would just put a caveat on anything that has been proposed by the White House that that is not holy writ brought down from the mountain by Moses. That is to be looked at by the Congress and we will make a decision.

The majority keeps holding hearings on supposedly bipartisan reform ideas, but over and over it is the same song: Cut the benefits, shift the costs to the poor and the elderly. These reforms were offered by the President in a spirit of a grand, balanced bargain. That package has shared sacrifice and included some spending cuts and revenue increases, but when it is cherry picked, when you catch the low-hanging fruit, they are nothing more than partisan cuts. How many times and how many ways can we rehash the same old idea? We have been trying to get blood from a stone.

Fifty percent of the Medicare beneficiaries in this country have annual incomes at or below $22,500. Our seniors, our parents, our grandparents, 50 percent of them are living barely above the poverty line. They should not be our go-to source for savings.

We are long overdue on fixing the physician payment system and I sincerely hope we can work in a bipartisan way to do it. In particular, we need to address inequities in payment for primary care physicians, and we need to do it in a way that encourages the most efficient delivery of health care so we can be pushing more of the right kind of care, not just more care overall.

Now let me be clear, and I am speaking as a physician here: It is the physicians who are driving the health care utilization in the system, not the beneficiaries. The notion that beneficiaries have to have more skin in the game to encourage smart healthcare shopping is ridiculous. When your doctor tells you, you need an extra test, or to come back in 2 weeks, how many of you poll other doctors to see if they agree? Of course not. There is a major information asymmetry between doctors and patients and a necessity to trust the physician's judgment. Few beneficiaries can distinguish between necessary and unnecessary care, and in the face of more cost sharing, they may forego both.

I would like to submit for the record a recent letter from the National Association of Insurance Commissioners in which they state that they were unable to find evidence that cost sharing encouraged appropriate use of healthcare services. In fact, they found that cost sharing would result in delayed treatments that could increase costs and result in negative health outcomes.

Mr. McDermott. As it is, Medicare households pay nearly 15 percent of their income on health care as compared to non-Medicare households, which pay 5 percent. As one of our witnesses, Joe Antos, points out in his testimony, higher income Medicare beneficiaries already pay more into the system, both through higher premiums and because they have paid more payroll taxes over the course of their working lives.

As for the notion of home healthcare deductible, these beneficiaries are some of the frailest individuals in Medicare. Why do Republicans insist on using this committee to go after them rather than building on the ACA's tools to fight fraud in this section?

It is fundamentally untrue that we have to cut Medicare in order to save it. If we are looking for offsets, we could focus on pharmaceutical companies' windfall from the Republicans' Part D drug benefit. Creating a drug rebate to capture that windfall would save $141 billion, the entire cost of the SGR fix. We could look to the providers with higher Medicare margins. MedPAC tells us that those margins mean payment rates are too high. Or we could look to the savings from winding down the wars in Afghanistan and Iraq. There are plenty of other savings to be found that don't involve jeopardizing the health and security of some of our most vulnerable Americans.

I look forward to this hearing and the witnesses' testimony. I think that we are faced with a question that we are going to have to face at some point. That is, how do you control costs in the healthcare system? I yield back.

Chairman Brady. Thank you.

Chairman Brady. And without objection, the document will be included in the record.

Today we will hear from three witnesses, Joseph Antos, the William H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute; Alice M. Rivlin, the Senior Fellow of Economic Studies at the Brookings Institute; and Joe Baker, president of the Medicare Rights Center.

I want to thank you all on behalf of Mr. McDermott and myself, thank you all for being here today. I look forward to your testimony. You will all be recognized for 5 minutes for the purposes of providing your oral remarks.

Mr. Antos, we will begin with you.

Mr. Antos. Thank you, Mr. Chairman.

Medicare is on a fiscally unsustainable path. Seventy-six million members of the baby boom generation will turn 65 and enroll in Medicare over the next 2 decades. According to AARP, that is about 8,000 baby boomers every day. The resulting costs will place a heavy strain on the Federal budget, crowding out other

spending priorities and burdening younger generations, and for that matter burdening older generations who will have to pay the rising costs of the Medicare program.

Comprehensive reforms are needed to ensure that Medicare will be able to continue to meet the needs of its beneficiaries over the long term. Bipartisan commissions, including the Bowles-Simpson commission, the Bipartisan Policy Center, the Medicare Payment Advisory Commission, and the Engelberg Center's Bending the Curve project concur on several principles that should form the basis of Medicare reform. One of those principles is addressed today, and that is the need to reform cost-sharing responsibilities to promote cost awareness and improve equity in the program.

Today's hearing focuses on three proposals advanced by the President: raising the Part B deductible, adding a copayment for some home health episodes, and increasing premiums for higher income beneficiaries. These proposals, as the chairman said, these proposals yield $54 billion in budget savings over the next decade. That is less than 1 percent of the $7.9 trillion that Medicare will spend over the same period.

These are modest changes, certainly financially, but they could lead to bipartisan discussions of broader reforms to protect Medicare for future generations. Medicare reform should create a benefit that is easy to understand and that protects seniors from catastrophic costs. That is a principle that I think is almost universally agreed, but the Medicare program is the way it is today for historical reasons.

The bipartisan commissions support proposals to simplify traditional Medicare's confusing benefit structure. If patients know what a health service will cost them, they will be more informed about their alternatives and will be better able to decide, with their physicians, about the best course of action. Replacing the multiple deductibles and complicated copayment structure in traditional Medicare with a simpler design typical of private insurance is one step in this reform. Limiting what Medigap plans cover so that beneficiaries pay some of the upfront costs themselves is another part of this reform.

The President's budget proposals are much narrower. The Part B deductible would be increased 75 years over 3 years. The new copayment would be levied on certain home health episodes that were not preceded by an inpatient stay. Both proposals would apply only to new Medicare enrollees as of 2017. Those proposals have been criticized as imposing a burden on beneficiaries. But in fact 90 percent of beneficiaries have supplementary coverage through Medigap, retiree plans, or Medicaid. Consequently, most beneficiaries have nearly complete coverage against out-of-pocket costs.

That fosters inefficiency in Medicare and adds to the costs of the program, which are borne by beneficiaries and taxpayers. I might add that for those who buy Medigap policies, they are simply paying it through another mechanism. They are still paying the cost.

So a more equitable phase-in than the President proposes would provide further protection for beneficiaries who do not already have supplementary coverage. The cost-sharing provision should be applied to all beneficiaries, not only to new enrollees, but exceptions could be made based on a beneficiary's ability to pay, health status, rather than the year of their enrollment.

The third proposal increases income-related premiums under Part B and Part D. This extends the principle that those with greater means should provide more support for the program, a principle embraced by Republicans and Democrats alike. This principle was embodied in Medicare at its beginning in 1965. High earners pay more in payroll taxes, as Mr. McDermott pointed out, and income taxes throughout their work lives. That started in 1966, and we still have this principle today.

How much they should pay is an ethical judgment, but if the budget resources are not available to maintain an adequate level of Medicare benefits for every senior, then we should care first for those who cannot afford to cover the costs themselves.

Increasing premiums reduces the fiscal pressure faced by Medicare, but it does not address the fundamental defects that drive up program costs. Higher premiums do not change the financial incentives of fee-for-service Medicare. They do not change the way beneficiaries use services, or the way services are delivered. More fundamental reforms that address Medicare's cost drivers are needed.

Any significant Medicare reform will take time to develop and implement. It is better to start that process now rather than delay until the fiscal crisis is upon us. Abrupt actions forced by crisis harm seniors and risk the long-term stability of the program. Proposals advanced by the President, as well as proposals from the independent commissions, potentially provide a basis for bipartisan agreement and the start of a process that can preserve and improve Medicare for future generations. Thank you.

Chairman Brady. Thank you, Mr. Antos.

Chairman Brady. Ms. Rivlin.

Ms. Rivlin. Thank you, Chairman Brady and Ranking Member McDermott.

Let me start with a basic question: Why reform Medicare? The main reason for reforming Medicare is not that the program is the principal driver of future Federal spending increases, although it is. The main reason is not that Medicare beneficiaries could be receiving much better coordinated and more effective care, although they could. The most important reason is that Medicare is big enough to move the whole American health delivery system away from fee-for-service reimbursement, which rewards the volume of services, and toward new delivery structures which reward quality and value. Medicare can lead a revolution in healthcare delivery that will give all Americans better health care at sustainable cost.

This committee knows very well that health care in the United States is expensive and getting more so. Moreover, quality is uneven, and much care is duplicative, wasteful, and uncoordinated. For decades, however, reformers have focused less on cost containment and quality improvement than on closing the gaps by widening healthcare insurance coverage. But now that the near universal coverage has been ensured by the Affordable Care Act, attention should shift to improving quality and value of healthcare delivery for all and containing cost growth.

I recently had the privilege of co-leading with former Senators Daschle, Domenici and Frist the Bipartisan Policy Center's report on the future -- on cost containment in health care. We reached a consensus on a comprehensive package of reforms that span the entire healthcare system with a particular focus on Medicare and Federal health-related tax policy. We believe that if enacted together, and that is important, these reforms will improve healthcare quality for patients and families and lower overall spending throughout the healthcare system.

Budget savings were not our primary objective, but we believe that these reforms would achieve approximately $300 billion in net savings over the next 10 years and about a trillion in the following 10 years. These saving estimates are net of the cost of fixing the dysfunctional sustainable growth rate physician payment formula.

Now, as has been noted, our bipartisan foursome were not mavericks working in isolation. The Simpson-Bowles commission, the Bending the Curve project at Brookings, and indeed the President's budget have endorsed many of the same proposals. It seems that a bipartisan consensus is emerging on using Medicare and tax reform to lead the transition of the health system away from fee-for-service and toward quality and value-based care.

Briefly, our recommendations included preserving the guaranteed health coverage promised in traditional Medicare; modernizing the benefit package for Medicare to create a cap on beneficiary cost sharing, a catastrophic cap which we don't now have; combining the Part A and B deductibles; and exempting physician visits from the deductible and preventive care from all cost sharing. We would limit Medicare

supplemental coverage, and we would protect low-income beneficiaries by helping them with cost sharing up to 150 percent of the poverty line. We would raise Part B premiums for higher-income beneficiaries in a slightly different way than the President does.

Most importantly, we would create Medicare networks, an improved version of the affordable care organization demonstrations in the Affordable Care Act. Medicare networks would be provider-led and enrollment-based, and would better provide coordinated care. Beneficiaries and providers would have incentives to join them, and reimbursement would be increasingly reflective of measures of quality and value.

We would replace the SGR with a better structure, and we would increase competition among health plans in Medicare Advantage by implementing a new competitive bidding structure that would result in lower payments and helping beneficiaries navigate plan choice on a user-friendly Web site.

We would also limit the tax-favored treatment of expensive health insurance products by capping the exclusion of employer-paid benefits. And we would have a cumulative limit on the increase in Medicare spending for each of the three categories that we propose.

This would not be an easy set of reforms to enact or implement, Mr. Chairman, but we believe it would improve the care delivery under Medicare and save money at the same time.

Chairman Brady. Thank you, Ms. Rivlin.

Chairman Brady. Mr. Baker.

Mr. Baker. Thank you, Chairman Brady, Ranking Member McDermott, and distinguished members of the Subcommittee on Health, for the opportunity to testify this morning about proposals to modify Medicare cost sharing. Medicare Rights Center is a national nonprofit organization dedicated to making sure that people with Medicare get access to affordable health care. We counsel about 15,000 people a year and their families and through for our education initiatives help about 700,000 others.

Proposals to increase the Medicare Part B deductible, introduce a home health copayment, and further income-relate Medicare premiums share a common pernicious theme: Each plan achieves savings by shifting cost to the very people Medicare was designed to protect.

Cost shifting to Medicare beneficiaries doesn't solve the underlying problem with our healthcare system: the long-term challenge of systemic healthcare inflation and costs, which threatens both the public and the private spheres. We believe that Congress should focus its attention on reforms that diminish wasteful Medicare spending and encourage the transformation of our healthcare system from one that rewards high-volume care to one that rewards high-value care.

To this extent, we support the proposals that would shift no costs, like advancing some of the delivery system reforms in the Affordable Care Act, restoring Medicare drug rebates, equalizing reimbursements to Medicare Advantage plans, and other proposals.

Today, as Ranking Member McDermott said, half of all people with Medicare, 25 million older adults and people with disabilities, are living on annual incomes of $22,500 or less and spending about 15 percent of their household income on healthcare costs as opposed to 5 percent for those under age 65 who are not on Medicare. These people with Medicare cannot afford to pay more for health care. Indeed, the most common call to our help line comes from a Medicare beneficiary having difficulty affording a treatment or a medicine. Further, forcing so-called wealthy beneficiaries to pay more for Medicare translates into a premium hike on middle-class retirees and people with disabilities while also fracturing one of our Nation's most successful social insurance programs.

Added cost sharing leaves many beneficiaries with no choice but to self-ration care. Faced with higher upfront costs, beneficiaries living on fixed incomes are likely to forego doctor's visits, a decision made on affordability, not on healthcare needs. Almost 40 years of data consistently demonstrates that while higher out-of-pocket costs certainly deter healthcare utilization, it deters utilization of needed care as well as unneeded care indiscriminately. The equation is simple: Higher out-of-pocket costs will require many Medicare beneficiaries to go without, either going without heating or rent payments, or going without needed medical care. And in the long run, reduction in the use of medically necessary care can increase healthcare spending through the increased likelihood of emergency room visits, ambulance rides, and hospital stays.

Increasing the Medicare Part B deductible, either alone or by combining the Part A and Part B deductible, is one of several proposals that adhere to the faulty logic that added cost sharing is an appropriate tool to limit healthcare service use. Most alarming about this proposal is that these added costs would impose greater hardship on beneficiaries with low fixed income. And with regard to the point about supplemental insurance covering this, many who would also increase the deductible would also decrease the level of coverage in Medigap or other Medicare supplemental plans.

Similarly, introducing a home health copayment would be most damaging to the most vulnerable -- the poorest, the oldest and the sickest. The typical home health user is an older, lower-income woman with one or more common or chronic conditions. Beneficiaries who need ongoing care to remain in their homes and not be institutionalized in nursing homes or other types of care are most at risk of skipping needed care if forced to pay this copayment.

Many policymakers suggest that wealthier beneficiaries can contribute more in Medicare costs, specifically through higher premiums. Yet higher-income beneficiaries already pay higher premiums, as we have heard. Achieving savings of any scope under these proposals requires reaching down the income spectrum. Recent analysis shows that individuals making $47,000 per year would pay more under current proposals. And that is a slippery slope. It could get lower and lower as this is looked at.

So we implore you to reject proposals that fail to build a better healthcare system, instead only achieve ephemeral savings by shifting costs to people with Medicare. Thank you for this opportunity to testify.

Chairman Brady. Thank you, Mr. Baker.

Chairman Brady. First to Mr. Antos, Ms. Rivlin. Medicare is so important. It is in deep trouble. Lawmakers like to bury their head in the sands on these tough issues. How important is it that we act this year to either save Medicare for the long-term or to take meaningful steps to extending its life, for example, another 20 years or more? Mr. Antos? Ms. Rivlin?

Mr. Antos. Well --

Chairman Brady. Act now.

Mr. Antos. Acting now is a critical matter. Congress has had plenty of opportunity to take appropriate actions over many, many years. But in fact we still face the fiscal problems and the risk to the Medicare program.

Chairman Brady. I have got a couple more questions for you, so your point is act now?

Mr. Antos. Act now, but act responsibly.

Chairman Brady. Got it.

Ms. Rivlin?

Ms. Rivlin. I would say act now, but for the principal reason that you can use Medicare to reform the whole system.

Chairman Brady. Yeah. Yeah. Do you see, as you look at these issues and the President's policies in his budget, income-related premiums for Medicare Parts B and D, the Part D deductible establishing a home health copay? The President has suggested this begin 4 years from now, 2017. Ms. Rivlin, do you see any reason we should wait that long?

Ms. Rivlin. I don't think you need to wait until 2017. You need a little time to get them in place and --

Chairman Brady. Yeah. Set them up.

Ms. Rivlin. Set them up. So it can't be 2014. I think we suggested 2016 as a reasonable year. But again, I wouldn't do these in isolation. Do them as a package.

Chairman Brady. Got it, makes sense.

Mr. Antos, you emphasized broad reforms of combining Medicare Parts A and B. This important topic, the subcommittee has been looking at and will continue to explore. Would you consider the policies we are discussing today to be smaller reforms on the pathway to perhaps bigger ones?

Mr. Antos. Well, they could be on the pathway to a discussion about combining A and B and more sensible reforms of Medicare. But these specific proposals I don't think take us in that direction. They are simply budget cuts.

Chairman Brady. Got it.

Ms. Rivlin, you -- and Mr. Antos, you both recommended establishing a home health copay so that patients determine the value of those services that is being provided to them. Some critics have warned it would deter many vulnerable Medicare beneficiaries from accessing needed care, maybe increase returning to hospitals. Can you respond to those criticisms?

Mr. Antos. Well, certainly, the President's proposal follows the Medicare Payment Advisory Commission's precaution and restricts this to episodes that have at least five visits and are not preceded by an inpatient stay.

Chairman Brady. So you are not coming from the hospital.

Mr. Antos. You are not coming from the hospital. Nonetheless, this is a serious matter. And the problem with a lot of Medicare policy is that it is very heavy-handed. We need to have a more subtle policy or we need to have a better management of patient care.

Chairman Brady. Should we adjust it to the income of the Medicare senior?

Mr. Antos. We certainly should recognize the extra burden that this is going to cause on the minority of patients who don't have the money.

Chairman Brady. Ms. Rivlin, your thoughts?

Ms. Rivlin. Home health care is liable to abuse, and I think that some cost sharing is appropriate. In our plan, we actually help the lower-income beneficiaries cope with total cost sharing, including any new cost sharing, so it wouldn't be subject to that criticism.

Chairman Brady. Yeah. And your belief is we are looking at value over volume. Is Washington the best one to determine what that value of service is, or are patients actually using them, you know, who have some role in some cost sharing, small or large, according to ability to pay? Is that where we see value more likely to be determined?

Ms. Rivlin. Well, when we talk about value and quality, we envision a set of measures that will eventually govern the reimbursement as we get more experience with them. I don't think you entirely rely on patients, as Dr. McDermott has suggested, to sort out what is quality. The point of cost sharing is to give patients some reason to stop and think, unless they are very low income, about whether they need to go.

Chairman Brady. That makes sense.

Mr. Baker, I just want to understand: You absolutely reject the President's proposals to begin some of these reforms in Medicare?

Mr. Baker. Yes, we think that the cost sharing as set is a blunt instrument and one that would visit some harm on beneficiaries.

Chairman Brady. Okay. Thank you.

Mr. McDermott.

Mr. McDermott. Thank you, Mr. Chairman.

I didn't take economics and so I am always pleased with the chance to learn from economists how they think. You take the average person is 78 years old, and he or she is living on $22,000 and spending about $3,000 on average, 15 percent, on their medical expenses, okay. So they are already spending a big chunk out of it.

Now, we are going to impose a tax on them. We are going to tax them -- we are going to call it a premium increase, but it is a tax. It is a tax on the seniors that we are putting on here. And I want to understand from the economist's point of view how imposing that tax on a 78-year-old senior who is living on $23,000 and spending $3,000 already on health care, how is that going to change the delivery of healthcare system to deliver quality instead of quantity?

I mean, I am trying to think of Mr. Johnson sitting there and saying, well, the doctor said I should come back and have my blood pressure checked, and it is going to cost me X number of dollars and so forth, and so I am not going to go. Or I am going to go because the doctor told me. How does this change the cost of overall Medicare by putting a tax on seniors of another 50 bucks a month?

Ms. Rivlin. That proposal is not what I -- tax on seniors of 50 bucks a month is not what I am advocating.

Mr. McDermott. You are not talking about the melding of the Part A and Part B?

Ms. Rivlin. We are.

Mr. McDermott. You are. So that means that the money that they pay will be more per month, right?

Ms. Rivlin. Let me finish. We do not propose a net increase in beneficiary cost sharing. The package that we would have, and it is a package, would reduce the cost sharing for low-income beneficiaries, increase it at the top. It would also make some very important changes in the benefit package that would say no deductible for going to the doctor ever, and no cost sharing at all for preventive care, and a cap on out-of-pocket spending. All of that is helpful to your average and below beneficiary.

Mr. McDermott. So then you are going to put it all on the richer people, that is the idea. Since it is not going to cost the poor people more, it has got to cost the richer people more, is that it? So you are putting the tax on the people above --

Ms. Rivlin. Well, we are increasing the Part B premium at, yes, for higher-income people. There is already an income relation, and we would lower the thresholds for that, but not to levels where people are in need.

Mr. McDermott. When does it tip over into being a welfare system? If you are poor you get it for free; if you are rich, you have got to pay for it. I mean, that is what we have now in the healthcare system in this country. If you are poor, you go to Medicaid, right? Or you just walk into the emergency room and get taken care of. The rest of us pay for it, and we are paying 1,000 bucks a year for the cost of the uncompensated care, presently. What you are doing is just shifting it to the top, is that what you are saying?

Ms. Rivlin. That is part of what I am saying, but remember, we don't pay for Part B. Right now the premiums cover only 25 percent of the cost of Part B. We would like the premiums to cover a somewhat higher share, and we would do that by raising the premiums for people like me. I am a beneficiary of Medicare who can afford to pay it.

Mr. McDermott. Mr. Baker, your view of this whole process?

Mr. Baker. Well, I think whenever you are talking about shifting the benefit, especially in the context of deficit reduction or for paying for other things, you are looking for savings. And in that context, even if you are protecting lower-income people --

Mr. McDermott. You are looking for savings or you are looking for more revenue?

Mr. Baker. Well, you are looking for revenue for the Federal budget, of course.

Mr. McDermott. So it is basically a tax.

Mr. Baker. It is a tax.

Mr. McDermott. You are taxing somebody to get more revenue into the system.

Mr. Baker. It gets more revenue into the system, and I think that the problem is, it doesn't solve the underlying problem, as I said, which are the healthcare costs themselves and inflation in that market, and it is a kind of a slippery slope. So once you start charging, say, people at $60,000 or $85,000 a year or more, and you can argue whether that is a wealthy individual when you look at our Tax Code, not necessarily as wealthy, of course, as someone at 450 or a million dollars where tax rates start to go up. But even for folks that are in that middle-income range, they do not qualify for low-income protection. They are strapped.

So, you know, you are looking at folks that are the most vulnerable, that have the least control over their utilization of health care, because as you had mentioned, once they get to the doctor and they are in the healthcare system, they are moving through that system. They are following doctor's orders. And I think that is where the incentives need to be placed on controlling care through accountable care organizations, some other mechanisms I think we all see as appropriate.

Mr. McDermott. Thank you.

Chairman Brady. Thank you.

Mr. Roskam is recognized for 5 minutes.

Mr. Roskam. Thank you, Mr. Chairman.

You know, it is interesting to take a step book and look at the trend and the history of this discussion. So the trend would suggest that income-related premiums and the discussion around them are here to stay. If you look at 2003, the decision by House GOP at that point to move forward on Part D and Part B; the decision by the Democrat majority in 2010 to move forward with similar themes as it relates to Medicaid and health exchanges in part D; the decision of the Obama administration, even if it is de minimis, they are acknowledging in their budget that it is here to stay.

So, Mr. Baker, I think that you are making yesterday's argument. Yesterday's arguments, they are nostalgic, but I think that the entire question, these numbers are so big, that have really eclipsed. Mr. McDermott raised this question about the economics of this, and that is sort of the wonder of it all, isn't it? That if you give patients choices, and not cutting out the legs from underneath the vulnerable that he is defending today, as well he should, but you look at the success of Part D, for example, a lot of the themes that we have heard in terms of criticisms of income-related premiums, we have heard those echoes in the past, and that was the claim that Part B was going to sort of lead to a very difficult situation, when as we all know, the data suggests just the opposite. Incredibly high satisfaction rate among seniors, you know, savings that have come in well under, you know, by 45 percent under the expectations. So that is part of the power of giving people choices and the ability to move forward.

Mr. McDermott mentioned a minute ago the idea of a senior being told, well, chase this down, you know what I mean, and come back and double-check your physician. Part of the other story, though, to complete the picture is, many times if you are told by a physician get an MRI, or whatever it happens to be, right now the system doesn't create an environment where you have much interest in trying to figure out who is doing the most efficient MRI? Where is the best, cheapest, and easiest, as opposed to the one that you just end up in?

Dr. Rivlin, can I ask you a question? With that sort of predicate, you made an interesting statement, and you said that the driving opportunity right now take the debt -- and it is a pretty provocative thing. You said the debt is a big question; set it aside. A more effective healthcare system is interesting; sort of set it aside. But you are telling this committee and this Congress that you have got such a big opportunity right now that you can have a transformational moment as it relates to Medicare. What did you mean by that?

Ms. Rivlin. The rising costs are not just in Medicare. They are in the whole system. And one of the culprits is the fee-for-service reimbursement system, which does, not surprisingly, reward more services, more volume, rather than coordinating care and rewarding value and quality.

We think that the accountable care organizations, we all think that accountable care organizations should be strengthened, provider-led networks that will take care of the whole patient, coordinates the care, and we think do it on a better, a higher quality basis, and a lower cost.

Now, time will tell whether that is right, but there is a strong feeling among health policy analysts that it is time to use Medicare to move the whole system off of fee-for-service.

Mr. Roskam. Thank you. I yield back.

Chairman Brady. Thank you.

Mr. Pascrell is recognized for 5 minutes.

Mr. Pascrell. Thank you, Mr. Chairman.

Ms. Rivlin, I think you have hit the nail on the head when you talk about Medicare and the whole system. Because I think one of the major problems we had in putting the ObamaCare together, in writing out the law, and it is voluminous pages, we have all heard, was that we often lose track that the person who is over 65 years of age many times has the same kinds of problems that a couple of 45 years of age have. And we have missed the point on this thing. When you shift costs, when you are shifting costs, as you laid out, you are not changing the cost, you are not lowering the cost. It is like the person who doesn't look at his hospital bill because it is covered, because I have insurance.

This moves the cost higher as well. I mean, many medical people don't want us to be knowledgeable of what is in the bill. And let's face it and let's say it like it is. I understand my colleagues on the other side continue to say that these proposed additional costs to beneficiaries are bipartisan proposals, I will have you know. But we must remember that the President offered the proposal in the context of a broad, large deficit-reduction package that requires both spending cuts and increased revenues.

We also need to remember that reform to the Medicare program is already underway. Why we will not admit to that, some on my side, and some on the other side, is beyond me. When we put the Affordable Care Act together, the purpose of that was to look at one of the specifics was Medicare and to reduce the cost.

And already, already, what we have done is the following: We have had entitlement change. We won't admit it. If you have Medicare, you qualify for an annual wellness visit, mammograms, other screenings for cancer and diabetes, important preventive care. Medicare Advantage plans that give better quality care receive additional bonus payments. Plans must use some of the bonus money to offer you added health benefits. Medicare Advantage plans cannot change -- or charge people more than the original Medicare pays for certain services. These services include chemotherapy administration, renal dialysis, and skilled nursing care. The law cracks down on waste, on fraud and abuse, a major part of that ObamaCare. Nobody refers to this. We have selective memory about what we want to think about or talk about in this legislation. And we guard against medical identity theft, et cetera, et cetera. It improves long-term care services.

Why not target when you say that we have got to move away from fee-for-service, not just for seniors, for everybody? For everybody? Can we say it enough times, Ms. Rivlin, for everybody? Because the costs are too high. And if we don't change those costs and find a way to do it without cost controls, then we are not going to have any system at all, not just we will reduce the propensity of Medicare and the strength of Medicare.

Overall health spending has been constrained. Per capita Medicare spending was 0.4 percent of GDP in 2012, last year. And CBO projects Medicare cost growth will remain low throughout the decade. There is a reason for this. Are there less people going into Medicare? Heck no. And overall health inflation has been at historic lows for 3 years in a row.

There is a report that came out this morning, I don't know if you saw it. Senior poverty is much worse than you think due in part to such burdens. The new Kaiser Family Foundation report finds that the SPM poverty rate for seniors is actually higher than the official rate, 15 percent versus 9 percent. And here we are talking about shifting costs, even if it is to the higher income. We better be darn careful about this, because if we don't understand the situation that seniors are in, we are in big trouble.

Mr. Baker, if I can get a quick question in. I think we are trying to go in a new direction here. I agree we should always be open to new ideas. I think my colleagues need to take a look at the work happening today that is moving Medicare; more important the quality than the quantity. Can you discuss the ways in which

affordable health care has helped the solvency of the Medicare program directly? Can you answer the question?

Chairman Brady. If I may, because time has expired, Mr. Baker, could you perhaps in another question or provide Mr. Pascrell by answering in writing. Thank you.

Mr. Pascrell. Thank you for your consideration.

Chairman Brady. Thank you, Mr. Pascrell.

Mr. Gerlach is recognized for 5 minutes.

Mr. Gerlach. Thank you, Mr. Chairman. Thank you for having this hearing today.

Today's hearing is focused on the reform of Medicare's benefit structure, so your suggestions are very welcome and very helpful. Thank you very much. But in addition to the benefit structure itself, success and cost-effectiveness of the program is also based on how it is administered every single day. Currently, the Medicare program has a pay-and-catch system for improper payments. A few years ago, the GAO put out a report that concluded that there is about $50 billion a year in improper payments made in the Medicare program, both unintentional payments, erroneous, mistaken, or intentional fraudulent-based payments due to stealing the identification numbers of physicians and other fraudulent activities.

So based on the fact that that $50 billion a year in improper payments in the Medicare program over 10 years would be half a trillion dollars, and based on the fact that that is about 10 percent of the total expenditure in the program each year, what do you each believe would be the single-most important step that Congress could take now to reduce and ultimately eliminate $50 billion a year in improper payments in the program in addition to all of the other suggestions you have given us about benefits restructuring? But specifically what could be done today to reduce and eliminate $50 billion in improper payments just because of the way the program is administered on a daily basis?

Start with Mr. Antos.

Mr. Antos. Well, certainly, the idea about Medicare verifying who the providers are would be the first step. Don't pay unless the provider is a legitimate provider. Don't pay unless the provider is providing appropriate services. The idea of having information about the quality of care should extend also to traditional Medicare. It doesn't exist there right now.

Mr. Gerlach. Thank you. Is there a specific kind of technology or system, programming that could be utilized to make that happen?

Mr. Antos. Well, so in terms of measuring quality, there are literally scores of different measures that measure very specific results or very specific activities in health care. They don't necessarily represent quality. They represent things we can measure. And so I think the first step is to do a better job of developing the kinds of measures that really reflect not what goes into the patient, but what comes out. In other words, patient outcomes.

Mr. Gerlach. Ms. Rivlin?

Ms. Rivlin. I agree with that, and I think more money for more vigorous prosecution of fraud would actually help. That is happening, but probably not enough. And better information for the patient to enable a patient to say, wait a minute, I never saw that doctor. It is hard now for a patient to monitor that kind of thing.

Mr. Gerlach. Mr. Baker?

Mr. Baker. I would agree with all that has been said. We get a lot of complaints on our help line saying I didn't see this particular doctor, and we do refer them to the fraud tip lines, et cetera, but sometimes it is the pathologist in the hospital that no one ever sees. That kind of education is important.

I think one of the things that we do have to guard against is one of the justifications for home health copayments is, oh, it will help combat fraud efforts. And I think putting financial cost sharing on consumers to have them help identify fraud is not necessarily the best way to go, but rather, some of the ideas that we have been talking about here, and really providing administrative resources to not only our law enforcement personnel, but also to the Center for Medicare and Medicaid Services to really oversee this program. We always brag about Medicare having a low administrative cost, but maybe it should have a little bit of a higher level of administrative cost so that it can pursue some of these initiatives against fraud.

Mr. Gerlach. Do either of you have a debit card on you today?

Mr. Baker. Yeah.

Mr. Gerlach. And you pull that card out, is there an identification number on that?

Mr. Baker. Yes, there is.

Mr. Gerlach. And if you took it downstairs to the credit union and you want to get money, you would type in a few numbers, would you not, that are unique to you and unique to that identification number, is that correct?

Mr. Baker. Yes.

Mr. Gerlach. And so why don't we have that system in Medicare right now? Why don't we have a smart card technology in our system that identifies that provider and that patient at the same time before the service is undertaken? Has anybody considered that as part of your review of the program?

Ms. Rivlin. Sounds like a good idea.

Mr. Gerlach. Okay.

Mr. Baker. We certainly could consider that.

Mr. Gerlach. I know when to end my questioning. Thank you, Mr. Chairman. I yield back.

Chairman Brady. Stop when you get the answer you want.

Mr. Price is recognized for 5 minutes.

Mr. Price. Sounds like a bill is coming, Mr. Chairman. Thank you. Thank you so much. And I want to thank the panel members.

This is a remarkably important topic, but it is also just part of a hugely complex system. And I am struck most often when we have the topic of health care come up in this committee, and appropriately so, we are talking about money, not about patients. And when you talk just about money and not about patients, then I think that we miss really the focus of where we ought to be. We ought to be talking about patients.

And as a physician taking care of patients for over 20 years, I know that the patients of this country, especially the Medicare patients of this country, are extremely frustrated with the current system. Access is being diminished to care. I have said this before, if you are a new Medicare patient, you turn 65, your physician that has been taking care of you isn't seeing Medicare patients, which is more and more frequent.

Even in large metropolitan areas, the opportunity or the ability that you have to find a doctor who is taking new Medicare patients is minimal. One in three physicians in this country has limited the number of Medicare patients that they are seeing. One in eight physicians who would normally see patients of Medicare age is not seeing any Medicare patients. And that is only getting worse. And the ACA is making that worse, not Dr. Price's, Tom Price's opinion. That is the opinion of the Medicare trustees, that access to care will be diminished because of the laws that we have already passed.

Mr. Antos, you talked about Medicare often times instituting policies in a heavy-handed way, and it is that heavy-handedness that I believe harms patients.

So there is huge pressure within the system, and I want to touch on a couple specific areas. And I know that the fee-for-service system has been bashed, and, you know, it isn't worth doggone thing, according to some folks. But one of the antiquated notions of the fee-for-service system is that a patient can choose a physician that he or she desires to take care of them and that that care can be delivered.

So I would ask you, Mr. Antos and Ms. Rivlin, do you believe that whatever system we come up with, should patients and doctors be able to practice outside of that system? Should they be free to take -- the doctor take care of a patient outside of that system if voluntarily the patient and the doctor desire to do so?

Mr. Antos. Well, under the Medicare program right now physicians are allowed to opt out, in essence. There are potentially substantial financial losses associated with that.

Mr. Price. How about for an incident of care right now?

Mr. Antos. For an incident of care, that is not possible. You are either in --

Mr. Price. Should it be?

Mr. Antos. It runs certain risk. I believe that this --

Mr. Price. The freedom runs the risk.

Mr. Antos. Freedom runs the risk. That is right. The question is, will the physician have the patient's best interest at heart or will the physician --

Mr. Price. Have you ever read the Hippocratic Oath?

Mr. Antos. I have read it, but there are plenty of ways to interpret it. And the question is --

Mr. Price. Can one interpret the Hippocratic Oath to not be in the interest of the patient?

Mr. Antos. Need to be in the interest of the patient, but the financial system that the physician is under in Medicare works across purposes oftentimes to the patient's --

Mr. Price. But coercion to the physician is not to provide the best care to the patient.

Mr. Antos. The financial system promotes oftentimes services that are not useful or not very useful to the patient.

Mr. Price. That is not the physician's design, that is the system's design.

Mr. Antos. That is the system's design, and so we need to reform the system in order to make that relationship between the doctor and patient much more productive.

Mr. Price. And maybe a little freer.

This is going in an interesting direction. So my time is about to run out and I want to get to this other issue. We seem to be having contradictory themes. We say that the government control will produce value, push value -- that is what we want, we want value -- yet some of the things like home health care that provide some of the highest value for patients or care in ambulatory surgery centers that provides some of the highest value for patients, this proposal and others dis-incentivizes the use of those. So you have got to ask the question, whose value? Is it the patient's value or the government's value?

Ms. Rivlin, whose value should we be talking about here, is it the government's value or the patient's value.

Ms. Rivlin. We should be trying to measure the value to the patient and rewarding that. It is not easy. And the question of home health care I think is a good example. Clearly it is valuable to many, many patients and you don't want to discourage it, but you don't want abuse either, and you have got to weigh the advantages and disadvantages of a copay.

Mr. Price. Complex issue, Mr. Chairman. Thank you.

Chairman Brady. Thank you.

Mr. Buchanan is recognized for 5 minutes.

Mr. Buchanan. Thank you, Mr. Chairman. I want to also thank our panelists today for taking your time to be with us.

I represent a community in Florida, Sarasota, but it is pretty much the demographics of Florida when you look across it, 700,000 people we all represent, 300,000 55 and older. But I went to probably a month back, went to an assisted-living facility in our area, these were seniors, very capable, active and engaged, and I usually go there once a year to talk to this group, 300 residents. So on the way in they mentioned to me, Vern, I would like to have you come meet a few of the residents, and very coherent. But I would say of the four I met, one was 108, there were three or four others in the assisted-living facility over 100. Another assisted-living facility in Venice, Florida, the average age, the guy had been there 40 years, it is a Lutheran organization that runs that out of Wisconsin, I think Wisconsin or Minnesota. He said the average age there today is 90, and he said 20 years ago it was 72.

So maybe it is just the sunshine in the State of Florida, I don't know, but I can tell you I am very concerned just looking forward from the viability as people are living longer. I think the statistics, the numbers used to be, people lived, when they put the program in place, I think it was 5 years. Today they claim 13.4 years. Have we looked at down the road the next 10 years or so of what the age that people are expected to live to or how many more years that is and we are factoring in the idea that the program, Medicare, is going to go broke in 10 years, Mr. Antos?

Mr. Antos. Well, certainly the Medicare actuaries take longevity into account. But longevity isn't the principal issue here, I don't think, it is the rising cost of health care, it is the rising use of services.

Mr. Buchanan. Well, you mentioned this, just real quick, how many people did you say come a day, are coming into the program at 65?

Mr. Antos. According to AARP it is about 8,000 a day.

Mr. Buchanan. Yeah, I have heard 8,000, 10,000, 12,000, somewhere in that, every day for the next 30 years.

Mr. Antos. Well, for the next 20 anyway.

Mr. Buchanan. Yeah, for the next 20. But go ahead, continue, what were you going to say?

Mr. Antos. They are youngsters. When you turn 65 you are basically a healthy person. It is at the other end of life where the money is being spent. And I think the issue here is not so much, we are not going have people stop turning 65 and joining the Medicare program. The issue is how do we get unnecessary spending under control? How do we get better treatment for these patients?

Mr. Buchanan. Ms. Rivlin, did you have any comments on those about longevity?

Ms. Rivlin. No, I agree with that. It is certainly increasing. But as Mr. Antos said, it is the rising cost per patient combined with the longevity, but the rising cost per patient is the really driving force.

Mr. Buchanan. The other thing I think that a lot of seniors are concerned about is the fact that we are not doing much about it. There is a 10-year window ideally. What is your opinion by waiting and not dealing with this in a real way? I mean, we are talking about some adjustments and things that we might be able do today, but in the scheme of things long term it doesn't seem like it is going to have a huge impact in terms of the overall dollars. By waiting, what happens from that standpoint? How long can we wait and not deal with it in a big way? Ms. Rivlin?

Ms. Rivlin. Every year you wait makes it more difficult. We have waited too long already on many of these things and I would include Social Security. We need to put all of these programs on a firmer basis.

But with respect to the healthcare programs it is a question of moving to better, more effective, more cost-effective delivery systems that is the most important. And the faster we can do that the better, although it is going to take time to transition.

Mr. Buchanan. Thank you, Mr. Chairman. I yield back.

Chairman Brady. Thank you.

Mr. Smith, you are recognized for 5 minutes.

Mr. Smith. Thank you, Mr. Chairman. And thanks to our witnesses for sharing your time today. I appreciate the testimony and your insight. And I think the urgency cannot be overstated. And yet we want to build on what we know works, and we want to do what we can to eliminate that which we know does not work.

I get a little concerned when the term "fraud" that we should all be concerned about is often used to describe what might have been an innocent mistake amidst a bureaucracy in piles and piles of paperwork, and we don't want the heavy hand of government to overreact. But I am curious to know what you might have to suggest about States coming up with innovative solutions. One thing we do know is that with our 50 States they are different among themselves. I know that, representing rural Nebraska, the definition of rural has a different application in different parts of the country. And so if you might, any of you, elaborate

on perhaps how we could maybe rely on the States for innovation and incentives to increase the effectiveness of care and access. Not all at once, but go ahead.

Mr. Antos. States obviously have a very strong fiscal interest in this question because of course they are responsible for about 42 percent of the cost of the Medicaid program. The Medicaid program, many Medicaid people are essentially young, relatively healthy people. But the older Medicaid beneficiaries are among the sickest and among the most expensive patients that we have. Many of them are dual eligibles in Medicare.

So States are very concerned about improving delivery of health care. I think in terms of rural America the idea of being able to bring modern electronics out there where you if can't get a doctor, let's get somebody who is trained at the local level and have communications back with a medical center.

In addition, States, I don't think States are rushing to do this, but increasingly we are going to need to look at the personnel who provide health care services. We are going to have a doctor shortage, there is no question about that. We are going to have a lot more people who will be demanding care, we are not going to be producing that many more physicians, because it takes so long to produce a physician, a good physician. So we are going to have to look at expanding the scope of practice for nurse practitioners, for example, physician's assistants. States control that, they need to take a look at that issue.

Mr. Smith. Okay.

Ms. Rivlin.

Ms. Rivlin. I would agree with that. It is the Medicaid program, which you ought to look to for giving States the most flexibility. And the potential is there. The situation now with waivers is much too complex, and it would be important, I think, to provide a more uniform system where States can take the measures that they think are most cost effective and are rewarded for that, but don't have to go through a very complicated waiver process.

Mr. Smith. Mr. Baker?

Mr. Baker. I would agree. I think some of the experimentation that is happening under the ACA but also outside of it with regard to dual eligibles, people that are eligible for both Medicare and Medicaid, and there the States really are pushing the envelope in many instances in combining those funding streams and coming up with creative ways to manage their care. The typical statistic is these are the 20 percent of people that generate 80 percent of the costs. If we can control those costs better, much of it through better coordinated care, managing that care better, breaking down those silos. And States have been doing that. And I think we need to continue to encourage that.

It is less possible in true rural areas that are sparsely populated, but some of the other ideas around allied professionals getting involved with physicians and others to kind of bring that care to the areas. Many times folks don't need that intensive medical care, they need kind of social supports or other supports, kind of live in their communities and stay healthy. And I think those are important initiatives that States are engaged in right now.

Mr. Smith. And, Mr. Baker, I think you touched briefly on perhaps cost sharing with emergency room or other areas. Could elaborate on that?

Mr. Baker. Well, my point there was that if we increase cost sharing up front, many times people don't access the kind of primary care or preventative care that they need. In many of the proposals preventive care would be covered first dollar up front, but other primary care would still need a copayment or a

deductible to get through. So what happens is people put off care, end up in emergency rooms, or higher, more expensive care settings.

Mr. Smith. Okay. Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Kind is recognized for 5 minutes.

Mr. Kind. Thank you, Mr. Chairman. I want to thank our panelists for your testimony today. Mr. Chairman, I hope this is the first of many more hearings that we can do to explore avenues of bipartisan cooperation on reforming a healthcare system that is in desperate need of reform. And I guess it is one of the frustrating things sitting here and listening even to today's conversation, is that there are so many of those tools that are currently a part of the Affordable Care Act right now.

Ms. Rivlin, delivery system reform, getting to a more integrated, coordinated, patient-centered healthcare delivery system. There are tools in the Affordable Care Act right now to drive the system in that direction, including payment reform. Demanding value-based payments, quality reimbursements, as opposed to volume is already in the Affordable Care Act right now and vast experimentation taking place. Would you agree with that assessment?

Ms. Rivlin. I agree with that, and I said that actually. And we want to strengthen and build on what is already going on and accelerate it.

Mr. Kind. And I applaud the work the Bipartisan Policy Center has come up with additional recommendations on reform. In fact, the New Dem Coalition just had Bill Hoagland and Chris Jennings before us to walk us through a lot of the recommendations, and many of which we embrace.

If there is one concern or one criticism I might have about the Bipartisan Center is you do maintain fee-for- service in a hybrid type of form, but nevertheless it is still there out in future years. And I happen to believe that we are going to have to kill this thing, we are going have to have a date certain on fee-for-service so there will be institutional pressure from all over to maintain a fee-for-service or volume-based payment system that we are never going to be able to slay and get rid of.

Ms. Rivlin. I think we kill it with incentives to move away from it, but we do preserve a choice so that no one can say we are destroying Medicare as we know it.

Mr. Kind. Well, and again in the whole topic of Medicare fraud, and I look forward to working with my good friend from Pennsylvania because I think he has some good ideas to bring to the table how we can do a better job. But, Mr. Antos, I don't know if you are sure, if you looked at the Affordable Care Act, but pay-and-catch is no longer the law of the land, it is a system of verification. And regional offices now have stepped up enforcement and funding to crack down or Medicare fraud. In the first 2 years we were able to recapture over $15 billion in fraudulent payments made in the Medicare system because of what is in the Affordable Care Act already. And that is moving forward. And maybe we need more personnel on the ground and more resources to do it, but again, as part of the Affordable Care Act, there has been a stepped-up measure to crack down on Medicare fraud. And I don't know, your testimony made me believe that you weren't aware that pay-and-catch is no longer allowed under Medicare.

Mr. Antos. Oh, I didn't address it in my written statement. It is not allowed but it still happens. It is great that CMS has been able to take actions, but obviously the problem isn't solved. The problem will never be solved.

Mr. Kind. Well, again I think we can continue working in a bipartisan fashion on what stepped-up enforcement are needed. There would be wide bipartisan support because no one is going to be here defending fraudulent practices, especially in the Medicare program.

But, Mr. Baker, I also notice that you have been one of the panelists on the second Institute of Medicine panel trying to change volume to value-based payments. My only encouragement to you and the panel, I know it is hard with peer review with IOM, you have got high standards, but you have to go bold and you have got to go courageous. And if you guys can't come up with a path to get to a fee-for-value-based reimbursement system it is going to be very hard for this institution to embrace something as well. So I don't know if you want to give us a quick update where IOM 2 is going right now, but soon you are going to be reporting out.

Mr. Baker. Well, we are in the peer review process so I can't really talk specifically about it. But I think that, as you saw from our interim report, we are very concerned about the present system. And I think you will be seeing some ideas about moving forward some of the value-based reforms that are already in the ACA. I think we are all agreed that those kinds of things and the kind of delivery system reform that we have all been talking about is key.

I would point out that, and I do believe that we need to move away from fee-for-service, as we have been talking about, but we also have to recognize that within some of these hybrid or some of these even in classic managed care fee-for-service is still used and still might be appropriate to encourage the provision of some services. So I think it is a hybrid system and one that definitely needs to move away --

Mr. Kind. I will need to be educated on the value of doing that, but I also agree with Mr. McDermott, if at the end of day all we are doing is talking about cost shifting, that is not the path forward because that is not the reform that we need to create the right incentives to get better value at a better price within the healthcare system. I think we are all in agreement on that. And my concern is with SGR fix and everything else that this cost -- and time is of the essence. The Ryan bill does nothing to reform Medicare for 10 years because they exempt the first 10 years of entrants into the program. So if time is of the essence, I don't know why we are repealing Affordable Care Act 37 times and then trying to move forward on a plan that does nothing for the next 10 years when 10,000 seniors are joining Medicare every single day in this country.

My time has expired, Mr. Chairman, thanks for your indulgence.

Chairman Brady. Thank you.

Mr. Thompson is recognized for 5 minutes.

Mr. Thompson. Thank you, Mr. Chairman. I want to thank all the witnesses for being here today and for your longstanding commitment to making health care work in this country.

I want to pick up where Mr. Kind left off, where Mr. McDermott started, and that is the whole issue of cost shifting. And one provision I would like to explore a little bit is found in the President's budget as it relates to a copay for home health care. And I, too, am worried about the idea that we would be cost shifting. And while the President's program saves close to $800 million -- I don't know if it does save that, but it is scored at saving $800 million -- and I just want to be very, very careful that we do the scoring correctly, because my concern is if this copay discourages folks from doing what they should be doing in regard to health care, it could end up costing us a lot more.

Specifically, if people don't get the care and they become more ill or they become injured and have to go into the hospital, that is a direct cost to Medicare and the Federal Government, or it could even turn out to be a cost shift to the specific States.

And on that note I would like to ask unanimous consent that we put in the record two letters from two different States who share the same concern, one from Governor O'Malley, a Democrat from Maryland, and the other from Governor Deal, a Republican and former colleague of ours from Georgia.

Mr. Chairman?

Chairman Brady. Without objection.

Mr. Thompson. And I think that is important to note that, and I would like to know what your thoughts are on that, and we can start with whomever. Mr. Baker?

Mr. Baker. Okay. Yes, I think that is a potential. I mean, in 1972 Congress actually took out copayment amount for the home health benefit after finding that it had led to increased hospital usage and institutionalization in other kind of more expensive and restrictive care settings. And I do believe that most of the savings that are scored there in the President's proposal they don't come from collecting the actual copayments, but come in from analysis about the utilization being tamped down and folks just not accessing the benefit at all.

And particularly the way this copayment is structured, as has been mentioned, is for people that have not had a hospitalization that need extended or longer-term care, even though Medicare doesn't cover long-term care per se. Some folks can get ongoing home health care needed in order to stay in their homes through the Medicare benefit. And those are the folks that are at risk of either hospitalization or of deterioration of their condition either leading to hospitalization or nursing home care.

So I think it is misguided, I think it is penny wise and pound foolish, as they say, and certainly to the extent it has the potential to lead to higher health costs, that was recognized in the early 1970s and I think that lesson should be relearned.

Mr. Thompson. Anyone else?

Ms. Rivlin. I think it is a difficult balancing act to the extent that there are people using home health care that don't really need it because there is no copay and you might as well. We need to discourage that and be careful that it doesn't hurt people who have very low income or who really need the care.

Mr. Thompson. Ms. Rivlin, I am glad that you raised that issue, because I suspect a lot of that savings is directed at detecting fraud abuse and getting away from that. But MedPAC has noted that there are patterns of abuse in home health care, primarily found in 25 different counties in Texas and Florida. So it seems to be a pretty focused issue or for the most part focused, and a pretty wide, sweeping way to deal with it. Is there a better way?

And I am glad that Mr. Gerlach raised the issue of going after the fraud because I am one who believes that we can accomplish a lot in fixing the system if we are able to nail the fraud stuff. Is there a better way to go after the fraud than the copay?

Ms. Rivlin. Well, there may be, but I think the copay would probably help.

Chairman Brady. Thank you, Mr. Thompson.

Mr. Blumenauer is recognized for 5 minutes.

Mr. Blumenauer. Thank you, Mr. Chairman. And I do appreciate an opportunity for a conversation like this, zeroing in on what actually can happen. And I want to follow up on comments from both my colleagues Mr. Thompson and Mr. Kind because I think we have got embedded in the Affordable Care Act some opportunity to change the delivery mechanism. We are doing some experimentation in Oregon, and we are optimistic global that it can have some significant effects. What Mr. Thompson said about being able to identify outliers, counties in a couple of States that are clearly having a pattern that screams abuse, the same way that we have had some pill mills where there are a handful of pharmacies that are responsible for certain narcotic drugs that find their way into the system. And I am a proud cosponsor of Mr. Gerlach's legislation for the secure card, which I think could help us get us at that.

I am open to other systematic adjustments, some of which have been proposed, Mr. Chairman, by some of your colleagues, some from the administration. But I am hopeful that we are able to focus on the big picture, things that we can do now that clearly attack problems of abuse and mismanagement that should share broad bipartisan support. And I am hopeful, Mr. Chairman, that our subcommittee could zero in on a few of these proposals that have bipartisan support on the committee, that aren't going to solve everything over night, but will make a significant difference improving the system.

I am of the opinion that the more we can do on some of these smaller things that will make a difference, that are bipartisan, that are not particularly controversial except for some people who are taking advantage of the system, will help us establish a foundation for what we are going to have to do for the next half dozen years as the nature of health care changes in this country.

And I will wrap up, we have got things to do. I don't want to debate particularly some of these modest points, although I would put on the table one other bipartisan proposal that will give people better health care, what they want, and will actually save money. And that deals with letting people know what they face at the end of life, that Medicare will pay untold billions to give hip replacements on 92-year old people in the last months of life, it will hook them up to machines, it will do anything, but it won't pay to have a conversation with the medical professional of their choice about what they face.

There is a reason why doctors actually consume less health care in their final months of life, because they know what they are facing, they know what works, they know what doesn't, and they have a way of making those decisions and making sure whatever the decisions are that they are respected.

And I would hope that there would be an opportunity for us to deal with legislation like that, that is bipartisan, that will make a difference, that surveys tell us over 90 percent of the American public wants, that will not just save money but will give people a better quality of care.

I appreciate your commitment to make the subcommittee zero in on some of the big picture, some controversial, some not. But I hope that we can circle around to some of the stuff that doesn't have to be controversial which will save money and bring the committee together while above our pay grade certain things are battled out. Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mr. Blumenauer.

Ms. Black for the final question.

Mrs. Black. Thank you, Mr. Chairman. And I appreciate for being able to sit here on the committee and given an opportunity to ask a question.

My question is going to go to two pieces here. One is the solvency and the other is the quality. And being a health care provider, as Dr. Price talked about, the quality is very important to me as well, is making sure that we have a system at the end of day that is solvent, that we can actually have a system.

So the current Medicare spending trajectory is unsustainable and we know that. It has actually led the Medicare trustees to estimate the Part A trust fund will go bankrupt in 2023 and insolvent in 2024. So that has already been established. But recent data has showed that Medicare spending is actually lower and some have suggested that this means that we don't need to make any changes to the program. And so I ask the panelists, and starting with you particularly, Mr. Antos, and then working down the line, wouldn't you agree that this is the wrong way to look at this?

And then, second to that, instead of waiting should we be acting now to extend the solvency of this program? And if we make those changes now would you agree that the changes would be smaller now rather than waiting? And then the end piece of that, can you discuss how you think a well-designed Medicare program would benefit the outcomes for our beneficiaries? So, Mr. Antos, can you go to that?

Mr. Antos. Thank you. What is lower now is not Medicare spending, what is lower is the last 2 or 3 years of growth per beneficiary. But of course the number of beneficiaries is growing every year. So in fact Medicare spending is continuing to grow, just at a somewhat slower rate than in the past. But we only have evidence for the last 3 years of slower Medicare spending. So I think it is way premature to announce victory and to hang up our hats.

Clearly, the sooner we take responsible actions to shore up Medicare financing and to improve the program so that it actually does a good job for patients, the easier the transition will be to whatever the new Medicare program will be. I tend to agree with many of the suggestions of the Bipartisan Policy Center and the other groups, certainly in general terms, and they all imply changes in the way patients act, physicians act, health plans act, and the traditional Medicare program acts. That is a lot of change, and that takes a lot of time. The sooner we start on that the more successful we will be without having what could be a disastrous experience for vulnerable people.

Mrs. Black. Thank you.

Ms. Rivlin?

Ms. Rivlin. I agree with all of that. I don't think it is the bankruptcy of Part A trust fund that should drive this primarily. You can always put more general revenues in the trust fund and you are doing that already in Part B. But the opportunity that you have now to change the way Medicare reimburses organizations and to incent more cost-effective delivery systems seems to me just major, and you ought to take it right away and push on that continuously.

There is no one thing you can do to fix the whole thing, we will all be back here again. But there is a big opportunity now to accelerate the reforms, many of which are already in the Affordable Care Act, to improve the delivery system for Medicare and the rest of the health system.

Mrs. Black. And might I add to that, because I think I heard you say earlier that one of the things you think is a benefit of this is that the quality of care is actually going to increase.

Ms. Rivlin. Yes, absolutely.

Mrs. Black. Mr. Baker, in my little bit of time I have left.

Mr. Baker. Of course. I think I agree with a lot of what has been said. I think the crisis isn't an acute crisis as it has been because of the slowdown in growth in Medicare costs. And if you are looking 10 years ahead we do have this window now where, if this projection keeps up -- and projections are projections, right -- but we feel that there is some breathing room. That doesn't mean we should be complacent. Definitely, as we have all discussed, not only in our Medicare program, but also in our private health

insurance and private coverage schemes we need to be looking at how to save money and, as you are saying, increase the level of quality of care and get higher value.

And so we think once again that some of the reforms in the Affordable Care Act, some of the things that are happening in the private sector that mirror that, and I agree with Ms. Rivlin that those things coming together and Medicare working shoulder to shoulder can drive a lot of good change. I mean, Medicare has had that role in the past and can have it now. I think my concern is that some of the cost sharing that we see here isn't driving in that direction.

Mrs. Black. Thank you, Mr. Baker.

Yield back.

Chairman Brady. Thank. On behalf of Mr. McDermott and myself, I would like to thank all three of our witnesses for their testimony today on the President's budget proposals. Your experience and ideas on how to reform Medicare to keep it solvent for our Nation's seniors are constructive, and your continued thoughts and feedback will be very helpful as we move forward with these efforts in the coming months.

As a reminder, any member wishing to submit a question for a record will have 14 days to do so. If any questions are submitted, I ask the witnesses respond in a timely manner, as I know you will.

Chairman Brady. With that, the subcommittee is adjourned.

[Whereupon, at 11:35 a.m., the subcommittee was adjourned.]

Public Submission for the Record

AARP

AFSCME

Alliance for Retired Americans

American Association of Bioanalysts

Center for Medicare Advocacy

National Association for Home Care & Hospice

National Association of Chain Drug Stores

National Committee to Preserve Social Security and Medicare

Pam Casper

Partnership for Quality Home Healthcare

Partnership for the Future of Medicare

Robert N. Young

Shannon Dwyer

St. Joseph Health

Texas Association for Home Care and Hospice

Torchmark Corporation

United Auto Workers

United Steelworkers

Virginia Association for Home Care and Hospice

Visiting Nurse Associations of America