MEDICARE PREMIUM SUPPORT PROPOSALS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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MEDICARE PREMIUM SUPPORT PROPOSALS

FRIDAY, APRIL 27, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:00 a.m., in Room 1100, Longworth House Office Building, Hon. Wally Herger [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Friday, April 27, 2012
HL–10

CONTACT: (202) 225–1721

Chairman Herger Announces a Hearing on Medicare Premium Support Proposals

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing to examine proposals to reform Medicare through a premium support model. **The hearing will take place on Friday, April 27, 2012, in Room 1100 of the Longworth House Office Building, beginning at 9:00 a.m.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of witnesses will follow.

BACKGROUND:

The Medicare program was enacted on June 30, 1965, when President Lyndon Johnson signed into law the Social Security Amendments Act (P.L. 89–97). At the time of its creation, Medicare's Fee For Service (FFS) design was modeled after the Blue Cross Blue Shield plans that were prevalent throughout the Nation. However, despite repeated and significant advances in private insurance over the last 45 years, Medicare's FFS delivery design has largely remained unchanged.

Medicare's FFS delivery system and its antiquated and siloed benefit design has also led to inefficiencies and financial challenges throughout Medicare's history. On numerous occasions, Congress has been forced to act to slow the growth of Medicare in order to extend the program's solvency. As a result, today's Medicare program is unsustainable. According to the 2011 Medicare trustees report, Medicare's Hospital Insurance Trust Fund is expected to go bankrupt by 2024, 5 years earlier than the trustees projected in 2010.

In announcing the hearing, Chairman Herger stated, **"The American public recognizes that today's Medicare program faces significant financial challenges. Unless Congress acts, the Medicare program that seniors and people with disabilities rely on will go bankrupt in just a few short years. In order to protect the Medicare program for future beneficiaries, Congress must look beyond simply slashing Medicare provider reimbursements, which will eventually result in beneficiaries losing access to care. The premium support model holds promise to place Medicare on sound financial footing while transforming and modernizing the program to provide greater choice for beneficiaries. Such proposals have enjoyed bipartisan support for decades, and it is time to move beyond partisan arguments and focus on the bipartisan solutions that will strengthen and improve Medicare for future generations of Americans."**

FOCUS OF THE HEARING:

The hearing will review the bipartisan support for implementing a premium support system in order to modernize the Medicare benefit while also improving the program's long-term financial solvency.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*Hearings*." Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, submit all requested information. ***ATTACH*** your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Friday, May 11, 2012**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov*.

Chairman HERGER. The Subcommittee will come to order.

We are meeting today to examine proposals to reform Medicare through premium support and the bipartisan support for such proposals.

First, I think it should be abundantly clear that despite what some on the other side might say, Republicans support the Medicare program. The program serves as a critical function in our society, ensuring that American seniors and people with disabilities have health care coverage.

Unfortunately, the program faces significant financial challenges and is slated to go bankrupt in 2024. We cannot keep tweaking here and tweaking there, hoping to kick the can down the road for a year or two. As the Medicare trustees again stated in their annual report, Congress must act sooner rather than later to reform the program to ensure its viability.

The Medicare program is in dire need of reform and improvement so that it meets the health care needs of its beneficiaries in the 21st century.

The traditional Medicare benefit was created in 1965 and it really hasn't been reformed since, despite the fact that the delivery of health care and the private insurance market have changed dramatically.

The Medicare fee-for-service benefit design, with its array of confusing coinsurance and deductible levels and its siloed delivery system, has not kept pace with the rest of health care. Can you imagine buying your hospital insurance from one insurance company, your doctor's office insurance from another insurance company, your prescription drug insurance from yet another company and catastrophic spending protections from a fourth company? That is exactly what the majority of Medicare beneficiaries do today. This outdated design breeds confusion, waste, and even fraud.

Medicare's antiquated design also inhibits care coordination, incentivizes overuse, and has led to financial challenges throughout Medicare's history.

So what is to be done? Simply hoping to make the Medicare program solvent by cutting payments to providers is unrealistic. The Chief Medicare Actuary has warned that the cuts already enacted as part of the Democratic health law would drive Medicare payments below Medicaid levels, which could result in "severe problems with beneficiary access to care." Further drastic provider cuts may make Medicare appear solvent on paper, but it would do so at the expense of the millions of seniors and people with disabilities who depend on the program.

Instead, we should examine reforms that will protect and improve the Medicare program, and premium support is one way to do that. Since the term "premium support" was coined by Henry Aaron, one of our witnesses here today, and Robert Reischauer, both Democrats, it has received bipartisan support.

Moving to a premium support model was advanced by the National Bipartisan Commission on the Future of Medicare, which was cochaired by Democratic Senator Breaux, another witness here today. Writing in support of the proposal, Senator Breaux and former Ways and Means Chairman Bill Thomas stated that they believe Medicare "can be more secure only by focusing the government's powers on ensuring comprehensive coverage at an affordable price rather than continuing the inefficiency, inequity, and inadequacy of the current Medicare program."

Premium support was also a key component of the recommendations from the Bipartisan Policy Center cochaired by Senator Pete Domenici and former CBO Director and Clinton Administration OMB Director Alice Rivlin, who is also testifying today.

It is in this vein that the 2013 House budget includes a premium support proposal. We have drawn upon the ideas that our witnesses have proposed over the past 2 decades and put forward a plan to protect Medicare for future generations.

There certainly will be differing opinions about how a premium support proposal should work. That is a healthy discussion. However, simply hiding our head in the sand is not.

House Republicans have made it abundantly clear that we will not simply watch Medicare become insolvent. My friends on the other side may not like our proposal to protect the Medicare program but where is yours? Relying on $14 billion in savings from so-called "delivery reforms" in the health care law is not going to save the program. They are already built into the Medicare trustees' estimates that predict Medicare's demise in just over 10 years.

There is some time before Medicare faces the dire shortfalls that would jeopardize access to care. However, we would be wise to heed the charge given to us by the Medicare trustees and begin to work together now to place the Medicare program on solid financial ground. It is my hope that today's hearing would be the beginning of this effort.

Before I recognize Ranking Member Stark 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.

I now recognize Ranking Member Stark for 5 minutes for the purpose of his opening statement.

Mr. STARK. I would like to thank Chairman Herger for holding this meeting. I think it is the first hearing that Republicans have held in the Ways and Means Committee to advance their plan to end the Medicare as we know it. Basically Republicans want to take away Medicare's guaranteed benefits and replace it with a voucher and put the insurance companies back in charge. I don't like their plan. I appreciate their honesty in flying their flag to dismantle Medicare high and proud.

This year they modified their plan by saying that traditional Medicare would remain an option. That promise isn't worth very much. Traditional Medicare might be theoretically available, but would be out of reach of many because the voucher would not be guaranteed to cover costs.

Traditional Medicare would undoubtedly attract sicker patients and quickly enter into a death spiral.

My Republican colleagues don't like the sound of voucher to describe their plan so they have made up a new term called premium support. They also dislike being the sole owners of this plan, so they are holding this hearing today. They want to share the blame and are trying to overshadow the fact that every single Democrat in the House of Representatives voted against their budget, which includes their Medicare voucher proposal. I can count on maybe one hand the Democrats who support vouchers or similar proposals.

Dr. Aaron actually has the dubious honor of having coined the phrase "premium support," but his written testimony today makes clear he is no proponent of the Ryan plan. The only Democrat I have heard say nice things about premium support is Ron Wyden, and he quickly disavowed the Ryan budget and said I didn't write it and can't imagine a scenario where I would vote for it.

I am going to go on record again making clear the strong opposition that Democrats have to the House Republican proposal. By any name it would be devastating to Medicare beneficiaries, raising their costs, negating the gains made from Medicare that ensure that all our seniors have quality affordable health care. Instead

they would return us to a time when private health insurers would control what care seniors get and what price they are forced to pay.

The CBO has said it would lead to an increase in overall national health spending as seniors and people with disabilities are moved into less efficient, more costly private plans. It simply takes us in the wrong direction.

Now, I have to agree with my chairman that there are reforms that we can and should continue to make to Medicare. I am proud of the provisions we included in the health reform bill that are already moving forward, payment and delivery system reforms. They are reducing overpayments to private health insurers and their plans to cost taxpayers tens of billions of dollars each year, adding years of solvency to the trust fund through our recent legislation. We did this while preserving and even improving Medicare benefits, proving that you don't have to kill the patient to save it.

With that, I look forward to hearing from our witnesses today. Thank you, Mr. Chairman.

Chairman HERGER. Thank you. Today we are joined by four witnesses, former Senator John Breaux, who chaired the 1999 National Bipartisan Commission on the Future of Medicare; Alice Rivlin, a Senior Fellow at the Brookings Institution and Cochair of the Bipartisan Policy Center's task force on debt reduction; Joe Antos, the Wilson H. Taylor scholar at American Enterprise Institute; and Henry Aaron, a Senior Fellow at the Brookings Institution. You will each have 5 minutes to present your oral testimony. Your entire written statement will be made a part of the record.

Senator Breaux, you are now recognized for 5 minutes.

STATEMENT OF HON. JOHN B. BREAUX, SENIOR COUNSEL, PATTON BOGGS, LLP

Mr. BREAUX. Thank you very much, Mr. Herger, for inviting me. Ranking Member Pete Stark, he and I have been involved in this for many, many, many years. Thank you all for inviting me. Jim McDermott, who served with me in a great capacity when we had the National Bipartisan Commission on Medicare Reform, and many of you who I have had the privilege of working with in different capacities. Thank all of you for inviting me to talk about one of the most important issues and at the same time one of the most divisive issues that either party is going to have to face, and that is what do we do with Medicare reform?

Let me say I had the privilege of serving in this body for 14 years in the House and 18 in the Senate, or the other body as we like to have called them over here in the House. So I think I fully understand the difficulties that each Member from each party has in addressing the very difficult issue of how we continue to provide quality health care for our Nation's seniors.

I have observed over the years that some Democrats, not all, but some have taken the position that in health care the government should do everything and the private sector should do nothing. On the other side there are some Republicans, not all, but some who take and argue the opposite position that the government should do nothing when it comes to health care and that the private sector should do everything.

My opinion is that in order to ever reach an agreement between the two parties, Congress is going to have to combine the best of what government can do with the best of what the private sector can do and put the two together. I would submit to this panel that that is exactly what we did in creating Medicare Part D. The best of what government can do in that legislation is, one, help pay for the program which the government can do through the taxation system. Second, government can help set up the mechanics and structure of the program with standards that the government would put into place. And third, government can make sure that private sector and companies do not scam the system and can actually deliver the product. Government does those things fairly well.

On the other hand, the private sector needs to be involved. The private sector can create competition among competing plans. The government doesn't create competition, private sector can do that. Second, private sector can bring invasion and new products to the market. Government doesn't do that very well. And third, the private sector can deliver beneficiaries' choices to allow them to select the best plan for themselves and their families.

Now our current Medicare program, as all of you know, was signed into law by President Lyndon Johnson back in 1965. And the model chosen to deliver those health benefits 47 years ago was the fee-for-service model, providers do the service and the government pays the fees. To control the cost the government fixes the price for everything from bed pans to brain surgery. Providers now get around the cost gaps by simply doing more services, and the program has remained much the same as it has for 47 years.

A former colleague of mine in the U.S. Senate was Harris Wofford, a great guy from Pennsylvania. He was a truly committed liberal who served with great distinction in the Kennedy Administration as well as in the Senate. He argued very strongly that American citizens should have access to the same quality health care that his or her Member of Congress has. He argued that if it was good enough for Members of Congress it should be good enough for all Americans. Now, what each of you have and your staffs and millions of other Federal employees, and myself included as a retired Federal employee, is a health plan that does combine the best of what government can do with the best of what the private sector can do. The Federal Employees Health Benefits Plan, enacted in 1959, required that the Federal Government write the regulations that set up the program and then pays up to 75 percent of the cost of the health benefits. The beneficiary then pays the rest based on a formula set by law. Over 350 private health plans are offered under the program and 14 or so are fee-for-service and the remainder are what is called premium support plans. Premium support plans have the government paying the 75 percent, and the government approves a group of private plans that employees can choose from that are required by our government to deliver the services. And all of this is implemented by the Office of Personnel Management.

When I chaired the National Bipartisan Commission on the Future of Medicare back in 1998 and 1999 we examined several options on how to improve Medicare. No one, Republican or Democrat, on that Commission wanted to end the Federal Medicare and

a strong majority, 10 of the 17, supported a new delivery system based on market based premium support system, where for most seniors the premium support would be set at about 88 percent of the standard plan. Unfortunately, the statute created at our Commission did not require a majority to report, but a supermajority, so our Commission's plan was never formally submitted to the President nor to Congress. However, what happened next was that then Republican leader Bill Frist and I developed complete statutory language, not an outline, not just a print, not just talking points, but complete statutory legislation and introduced S. 1895, which incorporated the fundamental principles of the Medicare Commission proposal.

The core recommendation of our bill was not to end Medicare but to rather restructure Medicare, using what each of you have today, the FEHB program, as a model.

Under our bill beneficiaries would be subsidized by the Federal Government for participating in any competing private or government plan offered under Medicare, including the existing fee-for-service program. The contribution amount by the Federal Government would be based—this is important—on the national average of the premiums for a standard benefit package, weighted by plan enrollment and adjusted for risk and for geography, not some arbitrary growth rate like GDP. That standard benefit package would be all services guaranteed under the existing Medicare statute, as part of the legislation. Breaux-Frist set the overall Medicare contribution at 88 percent of the national average cost of that standard benefit package. And under our plan the amount of Medicare's contribution would be guaranteed. Also, importantly, under our plan, for rural areas many of you represent, where competition is less likely, beneficiaries would be protected from paying premiums that are higher than the current Part B premium.

And finally we established the Medicare Board, and this would oversee competition among private and government sponsored fee-for-service plans and would be the equivalent of the Office of Personnel Management, which today manages the FEHB program. It would exercise its authority by regulation and negotiate with the plans. Overall the Commission estimated the proposal would reduce the Medicare growth rate by 12 percent.

One might ask the question, why tamper with Medicare at all? Why change the system that has worked well for 47 years? Well, I used to drive a 1965 Chevy II. I really loved that car. But I would hate to be driving it today, 47 years later, and keeping up with the maintenance of that car and I think none of you would want to do the same thing. Perhaps a better answer, however, to that question of why tinker with it now is a statement made by Rick Foster, Chief Actuary for the Medicare and Medicaid services, just this past week.

Mr. Foster said in the 2012 Trustees' Report on Medicare, "Without unprecedented changes in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services are very likely to fall increasingly short of the cost of providing these services."

Some good news out there now is that in addition to the important changes made in the Affordable Health Care Act, ObamaCare

made to those under 65 in the private insurance market through exchanges and other things, it also included promising reforms, moving away from traditional fee-for-service Medicare but still under the fee-for-service program. Things like value-based purchasing and bundle payment systems, where CMS will try to realign incentives and reimburse doctors and hospitals for the quality of the care they provide and not just the quantity.

Under the Affordable Care Act, CMS has already started testing new and innovative payment and delivery programs through the CMMI, the Center For Medicare and Medicaid Innovation. The goal of all these payment reforms and demonstration projects is to improve patient outcomes while lowering the cost.

In the event that we move to a premium support model where there is more price competition between fee-for-service and the private plans, the whole system is going to be better off if these promising fee-for-service Medicare reforms——

Chairman HERGER. Senator, if you could summarize.

Mr. BREAUX. I am summarizing, last paragraph. I used to stay that all the time, but they would never stop.

The great challenge today I would just suggest to both my Democratic colleagues and my Republican friends and colleagues, former colleagues, is how do both political parties bridge the gap between the different political philosophies and produce health care reform for America's seniors?

In 1965, a bipartisan Congress said that fee-for-service was the best delivery system back then. Let me suggest that in 2012 the best delivery system was still what is contained in the Breaux-Frist proposal.

If I can be of any help to any of you, please call on me, and thank you very much for your attention.

[The prepared statement of Mr. Breaux follows:]

TESTIMONY IS EMBARGOED UNTIL 9:00 AM FRIDAY, APRIL 27, 2012

Statement of The Honorable John Breaux
Subcommittee on Health, Committee on Ways and Means
US House of Representatives
April 27, 2012

Chairman Herger, Ranking Member Stark and members of the Committee, thank you for inviting me to testify on what is both one of the most important and at the same time divisive issues of our time – Medicare.

Let me say that I had the privilege of serving in Congress for 32 years, 14 in the House and 18 in the Senate. I fully understand the difficulties each Member has in addressing what needs to be done in providing healthcare to our nation's seniors. I have observed over the years some Democrats, not all, have taken the position that in healthcare, the government should do everything and the private sector should do nothing. On the other side, there are some Republicans, not all, who argue the opposite – government should do nothing and the private sector should do it all.

My opinion is that in order to ever reach an agreement; Congress must combine the best of what government can do with the best of what the private sector can.

I would submit this is exactly what we did in creating Medicare Part D. The best of what the government can provide is:

1. Help pay for the program.
2. Set up the mechanics and structure of the program with standards
3. Make sure the companies do not scam the system and can actually deliver the product.

The private sector can:

1. Create competition which lowers prices
2. Bring innovation and new products to the market
3. Deliver beneficiaries choices to allow selection of the best plan for them.

Our current Medicare program was signed into law by President Lyndon Johnson in 1965. The model chosen to deliver those health benefits 47 years ago was the "fee for service" model. Providers do the service and the government pays the fees. To control costs, the government fixes the price for everything from bedpans to brain surgery. Providers now get around the cost caps by doing more services and the program has remained much the same for 47 years.

A former colleague of mine in the United States Senate was Harris Wolford from Pennsylvania. Senator Wolford was a truly committed liberal who served with great distinction in the Kennedy Administration, as well as the Senate. He argued strongly that every American citizen should have access to the same quality healthcare that his or her Member of Congress receives. He argued that if it was good enough for Congressmen, it should be good enough for all Americans.

What each of you, your staffs and millions of other federal employees have (and I have as a retired federal employee), is a health plan that combines the best of what government can provide with the best of what the private sector can offer.

The Federal Employees Health Benefits Program (FEHB) enacted in 1959 required that the federal government write the regulations that set up the program and then pays up to 75% of the cost of the health benefits. The beneficiary then pays the rest based on a formula set by law. Over 350 private health plans are offered under the program - 14 are fee for service and the remainder are what is called premium support. Premium support programs have the government paying 75% of the premiums and approve a select group of private plans that employees can choose from that are

required by our government to deliver services. All of this is implemented and enforced by the Federal Office of Personnel Management (OPM).

When I chaired the national Bipartisan Commission on the Future of Medicare in 1998 and 1999, we examined several options on how to improve Medicare. No one, republican or democrat, wanted to end federal Medicare and a strong majority (10 of the 17) supported a new delivery system based on a market based premium support system where for most seniors, premium support would be set at about 88% of the standard plan. Unfortunately, the statute creating our Commission did not require a majority to report, but a super majority, so our Commission plan was never formally submitted to the President or Congress. However, what happened next was then Republican Leader Bill Frist and I developed complete statutory legislation and introduced S. 1895 which incorporated the fundamental principles of the Medicare Commission proposal.

The core recommendation of our bill was not to end Medicare, but rather to restructure Medicare using what each of you have today, the FEHB Program as a model. Under our bill, beneficiaries would be subsidized by the federal government for participation in any competing private or government plans offered under Medicare, including the existing Medicare fee for service program.

The contribution amount by the federal government would be based on the national average, weighted by plan enrollment and adjusted for risk and geography, of the premiums for a standard benefit package. Updates would be based on actual health care costs at that time—NOT some arbitrary growth rate like GDP. That standard benefit package would be "all services guaranteed under the existing Medicare statute."

Breaux-Frist set the overall Medicare contribution at 88% of the national average cost of the standard benefit package. Under our plan, the amount of Medicare's contribution would be guaranteed. Also, importantly, under our plan, in rural areas where competition is less likely, beneficiaries would be protected from paying premiums that are higher than the current Part B premiums.

Finally, we established a Medicare Board. This board would oversee competition among private and government sponsored fee for service plans and would be the equivalent to the Office of Personnel Management which today manages the FEHB Program. It would exercise its authority by regulation and negotiate with the plans. Overall, the Commission estimated its proposal would reduce the Medicare growth rate by 12%.

Some good news is that in addition to the important changes the Affordable Care Act (ACA) made to those under 65 in the private insurance market (through exchanges, etc), it also included promising reforms moving away from traditional FFS Medicare, but still under a fee for service program. Things like value-based purchasing and bundled payment systems where CMS will try to realign incentives and reimburse doctors and hospitals for the quality of care they provide rather than the quantity. Under the ACA, CMS has already started testing new and innovative payment and delivery programs through the Center for Medicare and Medicaid Innovation (CMMI). The goal of all of these payment reforms and demonstration projects in the ACA is to improve patient outcomes while lowering costs. In the event that we move to a premium support model where there is more price competition between FFS and private plans, the whole system would be better off if these promising FFS Medicare reforms in ACA work.

The great challenge today is how do both political parties bridge the gap between different philosophies and produce healthcare reform for America's seniors. In 1965, a bipartisan Congress said fee for service was the best delivery system, let me suggest that in 2012, the best delivery system is contained in the Breaux-Frist proposal.

Thank you for your attention.

Chairman HERGER. Thank you, Senator. Ms. Rivlin, you are recognized for 5 minutes.

STATEMENT OF HON. ALICE M. RIVLIN, PH.D., SENIOR FELLOW, ECONOMIC STUDIES, BROOKINGS INSTITUTION

Ms. RIVLIN. Thank you, Chairman Herger and Ranking Member Stark. I am delighted to have the opportunity to testify on reforming Medicare through a premium support model. Medicare is a hugely successful program that has dramatically increased the availability of health care to seniors, increased the length and quality of life of older Americans, and greatly reduced their fear of being unable to afford care when they need it. We need to preserve Medicare's guarantee of affordable health care for older and disabled people and make sure the program is sustainable as the number of beneficiaries explode and upward pressure on health care costs continues.

Medicare reform is not just about Medicare. Medicare plays a crucial role in two of the most daunting challenges facing American policymakers, the relentless increase and the proportion of the total spending that Americans collectively devote to health care and the unsustainable projected increase in publicly held Federal debt. Medicare reform represents an opportunity to turn this large publicly funded program into the leader in increasing efficiency of health care delivery for all Americans.

I believe that a well crafted, bipartisan bill that introduces a premium support model while preserving traditional Medicare can help achieve these goals. I will focus my remarks on the plan that former Senator Pete Domenici and I devised at the Bipartisan Policy Center, but it is very similar to the plan offered by Chairman Paul Ryan and Senator Ron Wyden.

Our proposal would preserve traditional Medicare as the default option for all seniors permanently. It would also offer seniors the opportunity to choose among comprehensive private health plans offered on a regulated exchange. These plans would be required to cover benefits with at least the same actuarial value as traditional Medicare and would have to accept all applicants and would receive a risk adjusted annual payment based on the age and health status of their beneficiaries.

The regional exchanges would collect and manage the prices and terms of competing plans within a designated region. And those plans would include traditional fee-for-service Medicare as well as qualified private plans. The government's contribution would be set by the second lowest plan in the region, subject to their having sufficient capacity.

With more accessible information about cost and patient outcomes, cost conscious consumer choice will lead the providers to emphasize preventive measures, managed care coordination of people with multiple chronic diseases and adopt more cost effective approaches to the delivery of care.

However, we don't know in advance what consumer driven competition will do. So we have introduced as a fail-safe, which we doubt will be necessary, a cap on per enrollee government premium contribution over time at the rate of growth per capita GDP plus 1 percent.

There are lots of questions about how well this would work. One is can't Medicare beneficiaries already choose among private plans under Medicare Advantage? They can and a quarter of them do, but Medicare Advantage wasn't properly structured to give full competition among plans. And our plan we think would structure the competition so that it actually lowered the rate of growth of cost.

And people question whether there is evidence that competition leads to lower cost and better quality. Actually despite its perverse features Medicare Advantage provides considerable evidence that competition works. The impression that it is more expensive derives from the fact that Medicare often pays plans more than the cost of fee-for-service. But under our plan that would not be possible and the competition we think would hold plans down.

Finally, would older and sicker seniors end up in traditional Medicare and raise its costs? This fear is based on the assumption that risk adjustment can't work and rules against cherry picking will not be enforced. But in fact we believe that these rules can work, that they are working better in Medicare Advantage than they used to and will work still better under a new system.

We believe that health care policy is far too important to be driven by a single party's ideology. No matter how the 2012 election turns out the President and congressional leadership should strive to find common ground on how to cover the uninsured, how to reform Medicare and Medicaid while stabilizing the debt. We believe that our plan contributes to that end.

Thank you very much for giving me the opportunity.

[The prepared statement of Ms. Rivlin follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 9:00 AM FRIDAY, APRIL 27, 2012

A Bipartisan Approach to Reforming Medicare

Testimony of Alice M. Rivlin[1]

The Brookings Institution and Georgetown University

Subcommittee on Health

Committee on Ways and Means

U.S. House of Representatives

Friday, April 27, 2012

Chairman Herger and Ranking Member Stark:

I am delighted to have the opportunity to testify on reforming Medicare through a premium support model. Medicare is a hugely successful program that has dramatically increased the availability of health care to seniors, increased the length and quality of life of older Americans, and greatly reduced their fear of being unable to afford care when they need it. We need to preserve Medicare's guarantee of affordable health care for older and disabled people and make sure that the program is sustainable as the number of beneficiaries explodes and upward pressure on health care costs continues.

Medicare reform is not just about Medicare. Medicare plays a crucial role in two of the most daunting challenges facing American policy makers: the relentless increase in the proportion of total spending that Americans collectively devote to health care (now about 18 percent of our gross domestic product (GDP) and rising); and the unsustainable projected increase in publicly held federal debt (now about 70 percent of GDP and rising). Medicare reform presents the opportunity to turn this large publicly-funded program into the leader in increasing the efficiency of health care delivery for all Americans – whether receiving care through public or private plans – improving the quality of health care services, slowing the growth of total health care spending at the

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[1] I am indebted to the staff of the Bipartisan Policy Center (BPC) and members of the BPC 's Task Force on Debt Reduction for assistance with this Testimony. The views presented are my own and should not be attributed to any of the institutions with which I am affiliated.

national level, and (by slowing the projected growth of Medicare spending) reducing the growth of future debt.

I believe that a well-crafted bipartisan bill that introduces a premium support model while preserving traditional Medicare can help achieve these goals. Since there are several versions of premium support, I will focus my remarks on the proposal of the Bipartisan Policy Center's Task Force on Debt Reduction, which I co-chaired with former Senator Pete Domenici (see attachment). This plan is very similar to the bipartisan proposal presented by Chairman Paul Ryan and Senator Ron Wyden in December, 2011.

Features of the Domenici-Rivlin Proposal

Our proposal would preserve traditional Medicare as the default option for all seniors permanently. It also would offer seniors the opportunity to choose among comprehensive private health plans offered on a regulated exchange. These plans would be required to cover benefits with at least the same actuarial value as traditional Medicare (including a specified package of services), would have to accept all applicants (absolutely no cherry picking allowed), and would receive risk-adjusted annual payments based on the age and health status of their beneficiaries. The regional exchanges would collect and manage the prices and terms of competing plans within a designated region (a metropolitan area or a rural area) that would include traditional fee-for-service (FFS) Medicare as well as qualified private plans. The government's contribution would be set by the second-lowest-priced plan in the region (subject to the two lowest-priced plans having sufficient capacity). Beneficiaries who chose the lowest-priced plan would get money back and those who chose more expensive plans would have to pay the difference.

With more accessible information about costs and patient outcomes, cost-conscious consumer choice will enhance competition among plans (including FFS Medicare) and will lead providers to emphasize preventive measures, manage care coordination of patients with multiple chronic diseases, and adopt more cost-effective approaches to delivery of care. We are confident that this process will reduce the rate of growth of

Medicare spending, just as similar market competition works to improve quality and reduce cost for virtually every other good or service in our economy and others around the world.

However, we do not know in advance what consumer-driven competition will do in the next ten years to improve quality and reduce cost for ***any*** good or service – automobiles, computers, haircuts, or (under our proposal) health care. If you asked the Congressional Budget Office (CBO) to "score" the effect of market competition on the prices the government must pay over the next ten years to buy computers or automobiles, CBO would tell you that they could not do so. CBO's response to scoring the effects of competition on health care would be precisely the same, for precisely the same reason. Therefore, as a fail-safe, our proposal would cap the per enrollee government premium contribution over time at the rate of growth of the per capita GDP plus one percent. Although we consider this eventuality unlikely, should the plans' pricing process result in a higher rate of growth, the additional cost would be reflected in an income-tested premium, with full protection for low-income seniors against higher contributions. Congress could, of course, over-ride this premium increase, and decide to reduce provider payments or increase the government contribution instead.

Some questions about the Domenici-Rivlin approach

Can't Medicare beneficiaries already choose among private plans under Part C or Medicare Advantage (MA)? They can and about a quarter of them do. However, MA proved more expensive to the trust funds than FFS Medicare because it was not structured to provide incentives for competitive cost reduction and quality improvement. Our plan would subsume MA and provide transparent competition on regional exchanges, where beneficiaries could realize benefits of choosing more cost-effective plans. The government would no longer have to pay extra to private plans when FFS Medicare provided lower-cost coverage (as is often true under MA) and would not pay more to provide FFS Medicare when private plans offer the care for less (as it currently does under MA).

We believe that the effectiveness of competition in driving down costs and improving outcomes would be enhanced by the transparency of competing on an exchange and the structure of the bidding process in our proposal. Beneficiaries would pay more attention, especially in areas where they could save money, because FFS Medicare premiums exceeded the second lowest bid. Plans would also have more incentive to seek efficiency when the bidding mechanism resulted in lower payments from the government than under the present MA system of administratively pegging payments to the cost of FFS Medicare.

Is there evidence that competition leads to lower cost and better quality? Actually, despite its perverse features, MA provides considerable evidence that competition works. The impression that MA plans are more costly on average derives from the fact that Medicare often pays more to the plans than the cost of FFS Medicare and that many of them offer supplementary benefits. But recent MEDPAC analysis shows that private plans offer the Medicare entitlement package itself for the same cost as FFS Medicare and HMO's in MA cost less than FFS. Competition works best in more densely populated urban areas, but that is where most of the Medicare population lives. In fact, 88 percent of Medicare beneficiaries live in areas in which a bidding process like the one we propose would produce a second-lowest bid below the current cost of FFS Medicare. In rural areas where FFS Medicare might remain the only available plan, our proposal would avoid any dislocation for those residents, because it would retain traditional Medicare as a permanent option. Furthermore, although existing systems that follow our general model are too small to have the same leverage over the entire healthcare market as would Medicare, evidence thus far is promising. Systems organized along these lines include the state employee systems for California and Wisconsin, and some employers including Stanford University. The Netherlands has adopted a similar national system, and experience thus far is favorable.

Won't older and sicker seniors end up in traditional Medicare and raise its cost? This fear is based on the assumption that risk adjustment can't work, and that rules against

cherry picking will not be enforced, so that private insurers will find ways to shun the elderly with the most-expensive conditions. In fact, however, risk-adjustment techniques improved substantially as relevant data and experience accumulated in MA and other programs, and can be expected to improve more. Moreover, some health plans are developing effective techniques for managing chronic diseases, such as diabetes, and are now actively trying to attract patients with these risks. Finally, the Federal Employees Health Benefits Plan demonstrates that an intelligently managed enrollment process can give consumers free access to all plans, without plan underwriting or selection.

Won't efforts to squeeze costs in Medicare just shift them to the private sector? Under the current system, with Medicare savings achieved largely through simple reductions in reimbursement rates, cost shifting has been a major concern. However, our proposal is driven differently. If competition works to produce more cost-effective delivery, Medicare can be a leader here. Plans and providers that have incentives to serve their Medicare patients more cost-effectively will do the same for their other clients.

Why not see how the Patient Protection and Affordable Care Act (PPACA) works before changing Medicare further? I support the PPACA and assume most of its provisions will be implemented – even if the Supreme Court makes it necessary to replace the mandate with other ways of encouraging more people to buy health insurance. The Center for Medicare and Medicaid Innovation, the Patient-Centered Outcomes Research Institute, and Accountable Care Organizations – all features of the PPACA – can help to assemble solid evidence about cost-effective approaches to delivering health care. If the Independent Payment Advisory Board (IPAB) functions as intended, it will design regulations that encourage more cost-effective delivery of care in traditional Medicare. However, it remains to be seen how well these new institutions will perform. We think it only prudent to strengthen competition as an additional tool. Under our proposal, competing health plans all over the country would have strong incentives, not only to implement innovative ideas coming out of the federally-supported institutions created by the PPACA, but to seek every possible way to provide higher-quality care at a lower cost in their own local area. The PPACA attempts to reward Medicare providers that meet the

conditions set in regulations. Enhancing competitive incentives to achieve savings and improve outcomes could prove the more effective approach. Our proposal is to try both.

How does the Ryan-Wyden proposal differ from Domenici-Rivlin?

The bipartisan reform of Medicare proposed by Budget Committee Chairman Paul Ryan and Senator Ron Wyden is very similar to our proposal – and significantly different from Chairman Ryan's earlier proposal incorporated in the House Budget Resolution passed in 2011. Unlike the earlier Ryan proposal, Ryan-Wyden preserves traditional FFS Medicare permanently, proposes a bidding process on Medicare exchanges, sets the government contribution at the second-lowest bid, and has a failsafe provision that caps increases in the contribution at GDP plus one percent – all features of Domenici-Rivlin. Two differences are worth noting here. Ryan-Wyden would phase in more slowly starting in 2022 and would only apply to new beneficiaries, while we would start in 2018 or even sooner. Ryan-Wyden also is more flexible about what would happen if the cap were breached, suggesting that Congress might choose among various kinds of reductions in provider payments in addition to the means-tested premium increase in our proposal.

Why is a bipartisan approach necessary?

We believe that health care policy is far too important to be driven by a single party's ideology. Programs that affect people's lives so intimately must flow from a broad bipartisan consensus. The public's health insurance coverage should not bounce around unpredictably with each party transition in an election. No matter how the 2012 election turns out, the president and congressional leadership should strive to find common ground both on how to cover the uninsured and how to reform Medicaid and Medicare while stabilizing the debt. Furthermore, the American people and the financial markets will have the most confidence in our success, and in the outlook for policy stability, if a Medicare solution rests on broad principles that both parties can accept.

Moreover, the two parties' competing ideologies can both contribute to improving health care outcomes and reducing the growth of costs. Republicans tend to rely on market competition and consumer choice to produce results in the public interest; while Democrats tend to rely on regulation. Republicans tend to distrust government; while Democrats tend to distrust profit-seeking in the private sector. But none of us is certain what will work best to reduce the growth of health costs, while improving health outcomes. The premium support model embodied in Domenici-Rivlin and Ryan-Wyden seeks to combine the tools of market competition and cost-effective regulation in hopes of maximizing the chances of improving health care for seniors at a sustainable cost.

Thank you very much for this opportunity to testify.

Chairman HERGER. Thank you very much. Mr. Antos, you are recognized for 5 minutes.

STATEMENT OF HON. JOSEPH R. ANTOS, PH.D., WILSON H. TAYLOR SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE

Mr. ANTOS. Thank you very much, Chairman Herger and Ranking Member Stark.

Medicare is a vitally important program but it is living on borrowed time. Medicare's Part A trust fund will be depleted in 2024, as you said, and the program faces $27 trillion in unfunded liabilities over the next 75 years. With retirement of 76 million Baby Boomers over the next 2 decade the program will consume an ever increasing share of the Federal budget unless policies are adopted to bend the Medicare's cost curve. Reform based on a principle premium support can responsibly slow the growth of Medicare spending and help set this country on a sustainable fiscal path. Such a reform relies on market competition among health plans to achieve high quality coverage at low cost. That is essential if we are to protect the Medicare program for future beneficiaries.

I will address four points about the design of a premium support reform.

First, should traditional Medicare be offered as a competing plan option under premium support? I think that is the most reasonable course. Perhaps as many as 57 million beneficiaries will be enrolled in traditional Medicare 10 years from now which is when most proposals will start competition under premium support. Traditional Medicare will not disappear when premium support begins, even if we do not allow any new enrollment. Moreover, traditional Medicare is likely to retain a stronghold in rural areas and other markets that are dominated by a few providers. For that reason we must find ways to reduce unnecessary spending in traditional Medicare in the near term as well as after premium support is in place.

Premium support does not need to exclude traditional Medicare. Premium support lets consumers decide for themselves which plan provides the best value and gives them a clear financial stake in that decision.

Second, will premium support shift huge new costs to Medicare beneficiaries? Let's be clear, the Affordable Care Act already shifts costs to beneficiaries. The law imposes unprecedented cuts in provider pay rates to generate $850 billion in Medicare savings over the next decade. According to the Medicare actuary, these payment reductions mean that 15 percent of hospitals and other party providers would lose money on their Medicare patients by 2019. That figure rises to 25 percent in 2030. Large across the board cuts in provider payments without changing incentives threaten access to care, and that is a real cost to patients that is not reflected in higher premiums.

In contract premium support changes the incentives that have driven up Medicare spending. Plans that hope to increase their profit margin need to seek more efficient ways to deliver necessary care rather than adding another test or procedure. There is plenty of room to improve efficiency in health care, and plans that ignore

opportunities to cut costs will lose market share and see their bottom line shrink.

There is also the market test in premium support. If private plans fail to offer a good product at a good price, beneficiaries will move to traditional Medicare which remains an option. This is an important safety valve that ensures seniors will be protected.

Third, what index should be used to limit the growth of Medicare subsidy? An index that ties Medicare spending growth to the economy, provides some budget discipline and helps with the CBO score, but let's not fool ourselves into thinking that the spending target is what produces the reductions in the cost of care. Efficiency and innovation in health care, in health care delivery determine whether Medicare savings can be sustained in the long term.

Finally, what other reforms are needed? We obviously needed modernized Medicare, we need to make the program fairer, we need to reduce unnecessary spending. That means we need better information, clearer financial incentives and a reformed subsidy structure that reinforces rather than undercuts efforts to slow spending.

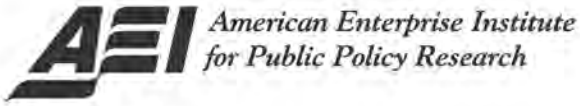
In my written statement I list a number of reforms. There are many that need to be done. Certainly reforming the confusing structure of traditional Medicare's cost sharing to make it more clear to people what they are paying would be a good first step in giving people good information about their health plans so that they can make good choices is absolutely vital.

So in conclusion, there is broad agreement that we need to bend the Medicare cost curve. The argument is only over how to do it. Premium support is not an academic theory, it has been effective in lowering cost and enhancing value in the Federal Employees Health Benefits Program for the past 5 decades and in CalPERS since the nineties. A well design premium support program can take full advantage of market competition to drive out unnecessary spending and increase Medicare's value to beneficiaries. It is about time we tried it, and I think we can find bipartisan agreement about moving forward.

Thank you.

[The prepared statement of Mr. Antos follows:]

TESTIMONY IS EMBARGOED UNTIL 9:00 AM FRIDAY, APRIL 27, 2012



Statement to the House Committee on Ways and Means,
Subcommittee on Health

Premium Support Proposals for Medicare Reform

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

April 27, 2012

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

Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify today before the House Committee on Ways and Means, Subcommittee on Health.

Medicare reform based on the principle of premium support can responsibly slow the growth of program spending and help set this country on a sustainable fiscal path. Such a reform relies on market competition among health plans to achieve high-quality coverage at the lowest cost. That is essential if we are to protect the Medicare program for future beneficiaries.

The annual report of the Medicare trustees issued earlier this week reminds us once again that Medicare is living on borrowed time. Even if the substantial reductions in payments to health care providers included in the Affordable Care Act (ACA) are fully implemented and Congress allows the 32 percent reduction in physician payments required under current law to go through in January, Medicare spending will continue to grow at unsustainable rates. Medicare's Part A trust fund will be depleted in 2024, and the program faces $27 trillion in unfunded liabilities over the next 75 years. With the retirement of 76 million Baby Boomers over the next two decades, the program will consume an ever increasing share of the federal budget unless policies are adopted to bend Medicare's cost curve.

Traditional Medicare's uncapped entitlement and fee-for-service payment structure is a major cause of the rapid rise of program spending. Fee-for-service payment promotes the use of more, and more expensive, services in a fragmented and uncoordinated delivery system. That results in higher cost and poorer patient outcomes.

Premium support changes that incentive by giving consumers a subsidy to purchase insurance from a wide selection of competing health plans offering a core set of benefits. In each market area, the plans would submit bids to provide the basic benefits to a beneficiary with average health risk. The subsidy would be based on the low bid, which under many proposals is defined as the second-lowest bid offered in that market. To ensure affordability, subsidies would be higher for beneficiaries with lower incomes or higher health risks.

Beneficiaries could enroll in more expensive plans, but any extra premium would be paid solely by the beneficiary without additional subsidy. That gives an incentive to consumers to select lower-cost plans, and it gives an incentive to the plans to negotiate lower prices with providers and improve the delivery of care. Instead of increasing the volume of services to increase payment, health plans would have a strong interest in providing necessary services in a cost-effective manner. Under premium support, more efficient health care delivery is rewarded, not penalized.

A number of bipartisan Medicare reforms that incorporate premium support in their design have been advanced over the past 15 years—including the Breaux-Thomas proposal developed for the National Bipartisan Commission on the Future of Medicare, the Domenici-Rivlin proposal developed for the Bipartisan Policy Center's Debt Reduction Task Force and recent proposals by Rep. Paul Ryan (R-Wis.) and Sen. Ron Wyden (D-Ore).[1] Each of those proposals addresses long-standing problems that threaten to undermine Medicare and jeopardize the country's fiscal future.

My testimony addresses four key issues in designing a Medicare reform based on premium support. First, the role of traditional Medicare. There are political and practical reasons to retain traditional Medicare as a competing plan option under premium support. Properly structured, premium support would not favor any specific plan over another.

Second, cost shifting to beneficiaries. Concerns have been raised that premium support would impose dramatically higher costs on Medicare beneficiaries. That ignores the cost shifting that is already in place under the ACA, which requires large across-the-board cuts in provider payment that threaten access to care—a real cost to patients that is not reflected in higher premiums. It also ignores the clear incentives that health plans would have to keep costs low, and it takes no account of the availability of traditional Medicare as a safety valve for beneficiaries should private plans fail to perform.

Third, indexing the growth of Medicare's subsidy. Most proposals include an index to limit future Medicare spending, which produces "scoreable" budget savings. The choice of an index is important, but efficiency and innovation in health care delivery determine whether Medicare savings can be sustained in the long term.

Fourth, additional reforms. Premium support by itself will not save Medicare. More immediate reforms are needed to modernize traditional Medicare and produce additional cost savings as we transition to full premium support. Our fiscal crisis is too urgent and Medicare's problems are too complex to delay action.

Traditional Medicare as an Option

Should traditional Medicare be retained as a plan option under premium support, or should it be phased out? Last year's House budget resolution included a premium support proposal that closed new enrollment in traditional Medicare beginning in 2022.[2] Individuals turning 65 from that year on would have a choice of private plans, but traditional Medicare would not be available.

Responding to concerns, the House budget resolution passed this year includes traditional Medicare as a plan option under premium support for all beneficiaries, including those who become newly eligible for Medicare. Although there are problems with either approach, retaining traditional Medicare as an option is the most reasonable course.

Some conservatives criticize this change as backsliding. They correctly see the traditional Medicare program in its current form as inefficient and anticompetitive. But pretending that the program will disappear in 10 years makes it unlikely that Congress would make important but difficult decisions needed to set traditional Medicare on a fiscally sustainable path.

The reality is that traditional fee-for-service Medicare could have some 57 million enrollees in 2023, when premium support would begin under the proposal.[3] Even without the current automatic assignment of newly-eligible beneficiaries to traditional Medicare, that

program could remain a dominant force in the health sector for decades if seniors continue to enroll. Prudent reforms, discussed below, are needed to make traditional Medicare less wasteful in the near term as well as after premium support is in place.

Traditional Medicare is likely to retain a strong hold in rural locales and other markets that are dominated by a small number of providers. In such cases, health plans may have little bargaining power to negotiate lower prices with providers. However, private plans may be able to rein in their operating costs through care coordination and other efficiencies that are outside the reach of traditional fee-for-service Medicare. In other markets where there is less concentration and more competition among providers, private plans are likely to have a competitive advantage over traditional Medicare. They should be better able to contract selectively in such markets, allowing them to offer lower-cost options to seniors.

The objective of premium support should not be to drive out traditional Medicare. Instead, premium support should be designed to allow consumers to decide for themselves which plan provides the best value, and give them a clear financial stake in that decision.

Cost Shifting and the Market Test

Will premium support based on full competition among private plans and traditional Medicare work? Some critics argue that premium support simply shifts the cost of care to seniors without improving the efficiency of health care delivery. That would be true only if there were no room to improve health care efficiency or if plans ignored opportunities to cut costs, increase market share, and improve their bottom lines.

Under a premium-support system, an additional test or procedure would not generate additional reimbursement from the government. Most Medicare beneficiaries live on fixed incomes and are not in a position to pay substantially more. That reality will force health plans and providers to coordinate patient care and find other efficiencies rather than perpetuating the current fragmented system. In a well-organized market, beneficiaries will be attracted to health plans that provide the most effective care at the lowest price.

The alternative offered by the ACA is not appealing. The law imposes unprecedented cuts in provider payment rates to generate $850 billion in Medicare savings over the next decade. According to the Medicare actuary, those payment reductions mean that 15 percent of hospitals and other Part A providers would lose money on their Medicare patients by 2019.[4] That figure rises to 25 percent in 2030 and 40 percent in 2050.

Under those circumstances, providers will have to withdraw from the Medicare program, causing growing problems for seniors needing care. Impeding access to care imposes real costs on patients that are not reflected in higher premiums, but they represent a cost shift nevertheless.

Retaining fee-for-service Medicare as a plan option in premium support creates a safety valve if the private plans are unable to rein in costs. If the critics are correct, traditional Medicare would be the low-cost plan in every market. Beneficiaries would move back to the traditional plan when the cost differences became apparent.

We can be reasonably confident that even the health sector will respond to clear economic incentives. In the unlikely event that delivery system improvements fail to materialize, beneficiaries would not be forced into poor-performing plans.

Limiting Program Spending

Medicare reform proposals that rely on premium support include an external constraint on program spending, typically limiting the annual growth in the subsidy to some economic index such as the gross national product (GDP). The proposal in the House Budget Resolution for fiscal year 2013 sets the limit at the GDP growth rate plus 0.5 percent, which is identical to the fiscal target set in the President's 2013 budget for the Independent Payment Advisory Committee (IPAB). The Wyden-Ryan proposal and the Domenici-Rivlin proposal, as well as the IPAB under current law, use GDP plus 1 percent.

The difference between those two growth rates can be substantial from a budget scoring perspective. If the growth in Medicare outlays was limited using GDP plus 1 starting in 2013, spending for benefits through 2022 would total about $7.7 trillion.[5] That is equal to spending under CBO's current law baseline (which includes the IPAB growth target in its projections). The trajectory of spending is lower than under the baseline, however, which suggests that GDP plus 1 would yield net budget savings in subsequent years. Using GDP plus 0.5 results in about $180 billion in budget savings through 2022, and considerably more in later years.

The target can be ratcheted up or down to achieve any level of scoreable savings demanded by political circumstances. Indeed, this type of fiscal control is often included in reform proposals to ensure that CBO produces a "good" score. But that does not imply that future Congresses will enforce the outlay limit or that such a limit is appropriate under future circumstances that are difficult to predict. Deterioration in the underlying health status of the Medicare population, for example, could drive up necessary spending even when care delivery is efficient.

Despite that uncertainty, it is useful to include a spending target in Medicare reform proposals. The Sustainable Growth Rate (SGR), which is intended to limit Medicare physician spending, is an instructive example. Although Congress has overridden the SGR repeatedly over the past 9 years, payment rates have grown less rapidly than they would have with the inflation adjustment built into the formula. Without the SGR, it is possible that Congress would have allowed larger annual updates.

However, we should not fool ourselves into believing that spending targets by themselves will produce savings that can be maintained over the long term. What matters most are the economic incentives brought to bear by premium support, which encourage better decision-making on the part of both consumers and health care providers. If competition can keep program spending within the bounds set by the targets, then the targets are not necessary except as a budgetary mnemonic device that reminds us that resources are limited, even for the most urgent of programs. If not, then the targets would eventually have to be increased unless a public

consensus had been reached that other spending priorities took precedence over health care, at least at the margin.

The Rest of Medicare Reform

Additional reforms are necessary to modernize Medicare, make the program fairer, and reduce unnecessary spending. In addition, some changes in Medicare rules would greatly enhance the effectiveness of competition among health plans and make traditional Medicare more competitive in local markets.

To help slow Medicare spending growth while providing greater financial help to those who are most in need, we need better information, clearer financial incentives, and a reformed subsidy structure that reinforces rather than undercuts efforts to slow spending. Such reform proposals include:

- **Establish clear cost-sharing incentives for beneficiaries.** Separate Part A and Part B deductibles, coinsurance and copayment requirements that vary across different types of services, and arbitrary gaps in coverage (such as the limit on lifetime hospital days) make it impossible for beneficiaries to know what their costs will be. A single deductible covering all Part A and Part B services with a uniform coinsurance rate applied to all covered services, similar to the design of most private insurance, would help clarify for beneficiaries what they are likely to pay.
- **Make cost-sharing requirements income-sensitive.** Medicare currently relates the premiums that beneficiaries pay for Part B and Part D. In addition, dual eligibles and other low-income beneficiaries receive additional subsidies that have the effect of income-relating benefits. This principle should be extended by increasing cost-sharing requirements for higher-income beneficiaries. Any specific dollar amount of cost-sharing has a greater impact on low-income beneficiaries. Income-sensitive cost-sharing would more effectively promote cost awareness across the income distribution.
- **Introduce true insurance protection into Medicare benefits.** Eliminating limits on inpatient days and adding coverage for catastrophic expenses would provide protection against high and often unexpected costs.
- **Recover the cost of induced utilization from stand-alone Medigap insurers.** Supplemental coverage pays Medicare deductibles and coinsurance, which largely eliminates financial incentives for conservative care on the part of both patients and providers. Medigap plans do not absorb the cost of the additional use of services that results, which are paid by Medicare as primary insurer. (This is not an issue for Medicare Advantage plans, which provide primary coverage as well as any additional benefits for a fixed per-beneficiary government payment.) Requiring supplemental plans to defray higher program costs would transfer the additional cost from taxpayers back to those who purchase and benefit from Medigap plans. An alternative approach would exclude Medigap coverage for the first $500 of a senior's cost-sharing and limit coverage above that to less than full payment.[6] The objective of this proposal combined with the three preceding ones

is to improve traditional Medicare so that there would be little need for beneficiaries to purchase supplemental insurance, but not to dictate how Medicare beneficiaries decide to spend their own money.

- **Offer care coordination services to beneficiaries who need it.** Traditional Medicare could improve patient outcomes and potentially reduce cost by providing care coordination to high-risk beneficiaries being treated by multiple physicians and other providers.[7] If used by patients meeting appropriate medical criteria, such a service would help minimize unnecessary testing, emergency room use, and avoidable hospital admissions.
- **Reform Medicare's payment systems.** The ongoing threat of massive payment cuts to physicians under the Sustainable Growth Rate should be replaced with a sustainable payment policy based on the principle of shared sacrifice. New payment approaches should be tested that can promote effective and efficient care. It will be necessary to limit any payment increases until a new payment mechanism has been developed. Similarly, other payment reforms—including bundled payments and competitive bidding approaches for specific services—should be developed and tested for their potential impact on cost and patient outcomes.
- **Improve the beneficiary purchasing experience.** Although the Medicare program offers tools to help beneficiaries make their decisions about enrolling in traditional Medicare or in an MA plan, as well as the choice of a Part D plan for those who opt for traditional Medicare, those tools are limited. Better information is needed on all plan combinations available to beneficiaries, including actual premiums (rather than ranges) for Medigap plans. Information is also needed on the likely out-of-pocket cost that a beneficiary would incur in the event of an unexpected high-cost change in health status. Beneficiaries need to know what a plan choice will really cost them, including both predictable costs (premiums) and unpredictable costs (cost-sharing and out-of-network expenses). Improving the insurance "exchange" function is essential in a premium support system.

Such policy improvements will take time to implement, but Medicare will continue to exert increasing pressure on the federal budget. Other actions to offset those costs include:

- **Increase Medicare premiums.** The Part B premium currently covers 25 percent of the cost of the benefit. In the short term, the premium could be raised to 35 percent, with higher premiums paid by higher income beneficiaries. Once Part A and Part B benefits are combined to simplify the cost-sharing structure, a premium that pays for an appropriate share of the combined benefit would make sense.
- **Increase the eligibility age to 67.** This proposal provides an incentive for seniors to remain in the work force longer, which would increase the amount of payroll tax receipts and somewhat reduce Medicare spending.

Conclusion

The debate over Medicare reform is about means, not ends. There is broad agreement that Medicare spending is on an unsustainable trajectory that threatens to crowd out other priorities elsewhere in the budget. There is broad agreement that Medicare's performance in delivering services to older Americans can and should be improved. There is great controversy over how to ensure that seniors continue to receive high-value health care at a price that is affordable to them and to taxpayers.

If we ever hope to bend Medicare's cost curve, we must change the financial incentives that drive program spending to increasingly unaffordable levels. A well-designed premium support program can take full advantage of market competition to drive out unnecessary spending and increase Medicare's value to beneficiaries. In a properly structured market, beneficiaries would have incentives to seek services from cost-effective delivery systems and providers would have incentives to operate efficiently.

The alternative approach relies on tighter regulation and cuts in provider payment rates without changing the underlying fee-for-service incentives that have driven Medicare spending to unprecedented levels. That is ultimately self-defeating, stifling private sector creativity rather than channeling it toward system-wide improvement.

The need for Medicare reform has never been more urgent, or more clear. Premium support is not an academic theory. It has been effective in lowering costs and enhancing value for five decades in the Federal Employees Health Benefits Program and since the early 1990s in the California Public Employees Retirement System.[8] It can work in Medicare, but only if we take the time to get it right.

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[1] Sen. John Breaux and Rep. Bill Thomas, "Building a Better Medicare for Today and Tomorrow," National Bipartisan Commission on the Future of Medicare, March 16, 1999, http://rs9.loc.gov/medicare/bbmtt31599.html; The Debt Reduction Task Force, "Restoring America's Future," Bipartisan Policy Center, November 2010, http://www.bipartisanpolicy.org/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf; Sen. Ron Wyden and Rep. Paul Ryan, "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future," December 15, 2011, http://budget.house.gov/UploadedFiles/WydenRyan.pdf; and House Committee on the Budget, "The Path to Prosperity: A Blueprint for American Renewal, Fiscal Year 2013 Budget Resolution," March 20, 2012, http://budget.house.gov/UploadedFiles/Pathtoprosperity2013.pdf.

[2] House Committee on the Budget, "The Path to Prosperity: Restoring America's Promise, Fiscal Year 2012 Budget Resolution," April 5, 2011, http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf.

[3] Author's calculations, based on 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 13, 2011, https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf.

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

[5] Author's calculation using CBO's estimated GDP growth rate of 4.7 percent between 2012 and 2022 and baseline spending estimates from CBO's March 2012 Medicare Baseline. CBO estimates that Medicare outlays for benefits in 2013 will equal $596.8 billion (net of the $4.6 billion dollar reduction due to the sequester called for in the Budget Control Act).

[6] See Sen. Joe Lieberman and Sen. Tom Coburn, "A Bipartisan Compromise to Save Medicare and Reduce the Debt," June 2011, http://lieberman.senate.gov/index.cfm/issues-legislation/health-and-social-policy/saving-medicare-the-liebermancoburn-plan.

[7] See Sen. Richard Burr and Sen. Tom Coburn, "The Seniors Choice Act," February 2012, http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=dd0753e9-e62b-4640-9659-75099f9bd1a9.

[8] Steven Findlay, "CalPERS: a model for health care reform?" *Business & Health*, June 1993, http://findarticles.com/p/articles/mi_m0903/is_n7_v11/ai_14046503/.

Chairman HERGER. Thank you, Mr. Antos. Mr. Aaron is recognized for 5 minutes.

STATEMENT OF HON. HENRY J. AARON, PH.D., SENIOR FELLOW, ECONOMIC STUDIES, BROOKINGS INSTITUTION

Mr. AARON. Thank you, Mr. Herger and Ranking Member Stark. Also special greetings to Congressman Price, with whom I have had the privilege of working in the past.

You have my written statement and I understand it is going to be entered into the record. I would like to begin with what I think is the central issue that divides those of us who are opposed to the premium support idea from those who are in favor of it.

I think all of us recognize that there are reforms to the existing Medicare program that could improve its operation. All of us would like to see cost competition play an enhanced role. All of us would like to see delivery system reforms that result in better quality and lower costs. And we hope they will work, but maybe they won't. If they don't, who bears the risk of costs rising faster than projections?

Under traditional Medicare those risks are pooled broadly across the population and over time across all Americans. Under premium support those risks are shouldered by Medicare beneficiaries who will be faced with higher out-of-pocket costs themselves. That is the choice I believe, the fundamental choice that needs to be made in determining a position on this issue.

Now some years ago Bob Reischauer and I, as you noted, coined this term "premium support" and we did so with respect to a particular plan, which was more than vouchers, and actually incorporated one of the features that Senator Breaux mentioned just now, that the index to which benefits are tied should be a health index not an economic index. And I would note that none of the proposals now under discussion meets Senator Breaux's standard in that respect.

In the 17 years since Bob Reischauer and I put this idea forward, I have changed my mind and I would like to just list a few of the reasons why I have changed my mind and I think I would urge you to consider them as well.

The whole environment of health care policy has been transformed. We wrote in the wake of the failure of the Clinton health reform effort and at a time when projections of insolvency of the Medicare Trust Fund were becoming steadily worse and were very near term. Both of those elements has changed. And in particular the passage of the Affordable Care Act means we have put in place a key element of the premium support idea for the rest of the population; namely, health insurance exchanges. We are finding those are difficult to implement. They are politically controversial. I think they will succeed and those problems are solvable.

The Medicare population is vastly more difficult to deal with than the population served under the Affordable Care Act. We should prove that the Medicare—that the health insurance exchanges work, get them up and running before we take seriously, in my view, calls to put the Medicare population through a similar system.

The regulatory climate has changed. It is far more hostile to the kinds of regulatory interventions, pretty aggressive regulatory interventions that Bob Reischauer and I thought were essential to the functioning of a premium support plan.

We at the time said that no premium support plan should move forward until risk adjustment was good enough to discourage competition based on risk selection. At the time, like Alice, we thought oh, well, it is doable, some time it will happen. Alas, it hasn't happened yet. A recent study has shown that the risk adjustment algorithm used under Medicare Advantage actually has increased the degree of risk selection that occurs through Medicare Advantage. We are not there yet. When we are, that would be the time to consider whether premium support merits consideration.

And finally, the idea that competition is going to save money, as an economist I really want to believe that. I got my degrees in that and I was pledged to like markets, I really do. The evidence to date is not encouraging. The higher costs of Medicare Advantage are not attributable solely to the extra payments that are made to them, nor is it attributable to a selection of patients. After controlling for all of those factors, Medicare Advantage plans are more expensive than is traditional Medicare. Furthermore, even Part D drug benefits which have come in below cost have come in below cost by less than other drug spending outside of the Medicare system has come in below the projections that were made at about the same time.

So I want to believe that competition will work and save money. The evidence is not supportive at this time. And given the risks involved it seems to me important to continue to spread the risks from rapid growth of health care spending across the general population rather than to impose them on a very vulnerable group of people, the elderly and people with disabilities.

Thank you.

[The prepared statement of Mr. Aaron follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 9:00 AM FRIDAY, APRIL 27, 2012

Statement of
Henry J. Aaron[1]
before the
House Ways and Means Health Subcommittee
27 April 2012

Mr. Chairman:

In my statement I shall emphasize the following points:

- Medicare has been an overwhelming success in providing access to care for groups that before its enactment had only limited access to insurance or standard health care. It is popular across the political spectrum. Polls reveal that people would rather raise taxes than cut its benefits.
- Neither part B nor D faces any problem insolvency. They are adequately funded in perpetuity under current law.
- The Part A trust fund is currently in better shape financially than it has been for most of its history. If all provisions of the Affordable Care Act are enforced, its financial gap is small.
- Many are concerned over Medicare's long-term affordability. If provisions of the Affordable Care Act are enforced, the added budget costs of Medicare over the next quarter century are modest and affordable.
- Medicare has evolved in important ways, pioneering new payment systems that private plans then emulated. Under the Affordable Care Act, Medicare can continue to serve as a powerful instrument to effect systemwide payment and delivery reform.
- The concept of premium support dates from the mid-1990s (the concept of 'vouchers' is older). None of the plans now under discussion qualifies as 'premium support.' This is not a matter of semantics. Important policy elements distinguish current plans from premium support. Furthermore, none of the proposals to change Medicare have been specified in sufficient detail to let one know exactly what is being proposed.
- The conditions that recommended premium support in the mid-1990s no longer apply. The current Medicare program already fosters competition between publicly-administered, traditional Medicare and private plans. Current privately-administered plans raise costs.
- Changes to Medicare, implemented within the current framework, can save money and improve quality of care.

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[1] Bruce and Virginia MacLaury Senior Fellow, The Brookings Institution. The views expressed here are my own and do not necessarily represent those of the trustees, officers, or other staff of the Brookings Institution.

I

Since its enactment in 1965, Medicare has been one of the most popular federal programs. It brings standard health care to the elderly and people with disabilities. Both groups lacked such access before Medicare was enacted. Medicare pools risks both across the population and through time. It spreads risks more effectively than does any private insurance pool.

Despite criticisms of the program it remains popular.[2] By a margin of 70 percent to 25 percent, respondents say they want to keep Medicare as it is rather than replace it with an arrangement under which beneficiaries would be given money they could use to buy private or public coverage.[3]

- Support for the current program was strongest among self-identified Democrats.
- Support among self-identified Independents was nearly identical to the national average (71 percent to 24 percent).
- Self-identified Republicans also favored continuation of the current program by a 53 to 39 percent margin.

A *Washington Post/ABC* poll, reported in *Politico* last year, found that a 53-45 majority said that they would prefer raising taxes on all Americans to cutting Medicare. Seventy-two percent of respondents said they would favor raising taxes on those with incomes of $250,000 or more as part of a deficit reducing plan; only 21 percent said they would approve cuts in Medicare as part of a deficit-reducing plan.[4]

II

There is widespread misunderstanding of Medicare's finances. First, many confuse the trust funds with the budget. Second, many ignore the qualitative differences between the rules governing part A, Hospital Insurance, on the one hand, and those governing Supplemental Medical Insurance, parts B and D.

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2 The Henry J. Kaiser Family Foundation, Kaiser Health Tracking Poll, February 2012

3 The exact wording of the question is: "Which of these two descriptions comes closer to your view of what Medicare should look like in the future? Medicare should continue as it is today, with the government guaranteeing seniors health insurance and making sure that everyone gets the same defined set of benefits, OR, Medicare should be changed to a system in which the government would guarantee each senior a fixed amount of money to put toward health insurance. Seniors would purchase that coverage either from traditional Medicare or from a list of private health plans."

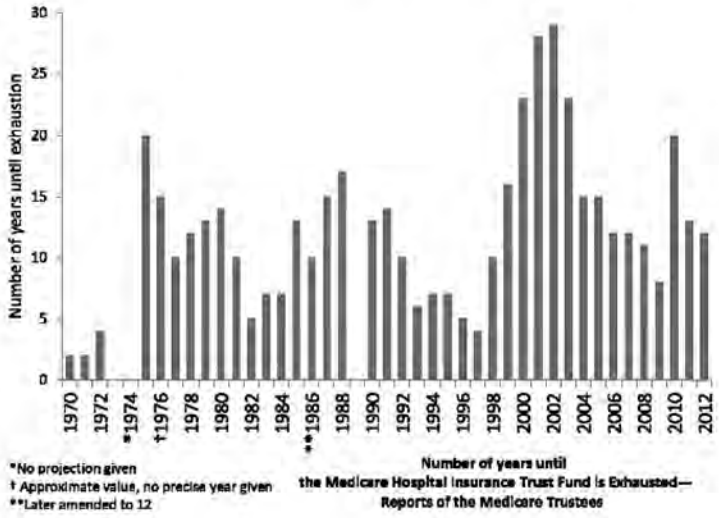
4 Jennifer Epstein, "Poll: Taxing the rich favored over Medicare cuts," *Politico*, 20 April 2011.

Part A is financed almost exclusively by earmarked taxes and interest earnings on reserves accumulated from past surpluses. Part A outlays can exceed revenues. Resulting deficits can deplete the trust fund. In contrast, parts B and D are financed by premiums and by general revenue payments that cover all program outlays not covered from other sources. Under current law, Parts B and D are fully financed in perpetuity. While it makes sense to talk of the solvency or insolvency of part A, it makes no sense to talk of solvency of parts B and D.

That said, all Medicare outlays are relevant to overall budget policy. Current concern about projected budget deficits is intense. It is important, therefore, to scrutinize total Medicare expenditures and consider how the program should be designed to use funds most effectively.

Solvency of Part A. The solvency of Hospital Insurance has been a topic of discussion, legislation, and controversy since Medicare was enacted. Each year, the Medicare trustees

Figure 1



present estimates of the number of years remaining until the Part A trust fund will be exhausted under current law. Figure 1 reveals that projections of imminent insolvency are not new. For

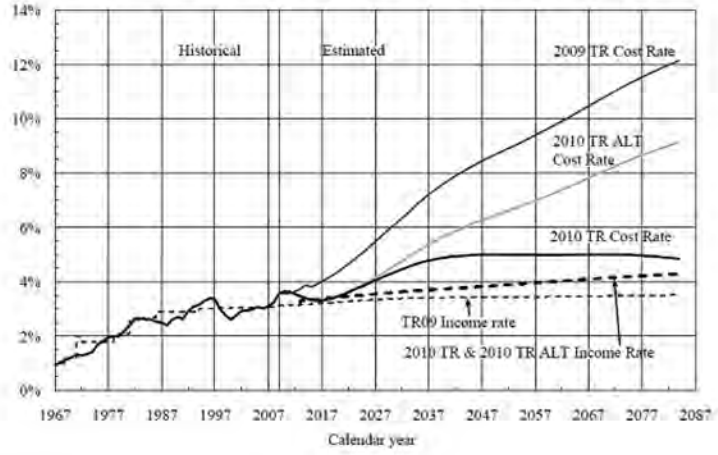
example, writing in 1999, National Bipartisan Commission on the Future of Medicare wrote: "Without structural changes, the Medicare system will be bankrupt in 2010."[5]

It didn't happen. Nor has any other projection that the HI trust fund will be depleted been correct. The reason is quite simple. People like the program. Elected officials know that their constituents like the program. So, the elected officials have done what needs to be done to keep the program solvent. In the background is another fact—anticipating how fast health care spending will grow is difficult. In some cases, underlying trends have turned more favorable than assumed. Sometimes Congress has simply shifted part A activities to part B to be paid by general revenues. The bottom line is the same: Congress has acted to prevent insolvency. It has done so because the program is popular and highly beneficial.

Figure 2 underscores the sensitivity of projections of balance in the part A trust fund to underlying assumptions.[6] Full enforcement of the provisions of the Affordable Care Act will

Figure 2

Projected Hospital Insurance Trust Fund Balance, 2010



5 http://rs9.loc.gov/medicare/talking.htm

6 John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers " 5 August 2010, Center for Medicare and Medicaid Services, Office of the Actuary, p. 13

greatly reduce the projected difference between earmarked revenues and projected outlays. As Figure 2 shows, the projected gap between cost and income was projected to be large and growing in 2009 before enactment of the Affordable Care Act. Full enforcement of the Affordable Care Act will reduce the gap and cause it to shrink over time. Many observers have expressed doubt that the targets in the Affordable Care Act can be enforced indefinitely. An expert panel, impaneled to review these targets, has yet to release their report. Through conversations with the chair and one panel member, I have learned that the group was divided on whether the spending targets can be sustained indefinitely but that the prevailing view was that they can be met for ten to twenty years. The United States now spends so much more for health care than other countries do that there is a large opportunity for reducing the growth of spending in the near term and to do so without rationing.

In summary, what figures 1 and 2 show is that to infer 'unsustainability' from the fact that the Medicare trustees foresee a date when the trust fund is projected to run out of money if nothing is done is unjustified.

III

While observers have documented many problems with the U.S. health care system, there is no evidence that Medicare performs less well than the rest of the health care system. In fact, for the last couple of decades, per enrollee Medicare spending has been growing at about the same rate or a bit more slowly than has per person health care spending for the general population. The United States faces a challenge to reduce waste and improve efficiency throughout its health care system. That challenge is no greater for services paid for by Medicare than it is for services paid for by private insurers, as all patients are cared for doctors and hospitals who care for Medicare and non-Medicare patients alike.

Over its history Medicare has pioneered reforms in health care payment. Prospective payment, a major cost-control innovation, was introduced in Medicare. Accountable care organizations, a promising innovation that can change incentives for the efficient delivery of care, will use Medicare to deliver those incentives. Bundled payments are widely regarded as a way to counter the excessive fragmentation of current health care delivery. While many problems have to be addressed before this reform can be carried to national scale, Medicare, as the largest single health care payer in the nation, could hasten the adoption of such reforms. The simple fact is that Medicare is a very large purchaser. With size comes clout—more clout than any private buyer has. To be sure, clout carries risks—by squeezing down payments. Medicare could simply force other payers to bear overhead costs. But clout also brings the capacity to shift incentives—and, if used wisely, to drive reform.

IV

For at least three decades some people from both parties have proposed replacing traditional Medicare with a single cash payment—a voucher. Beneficiaries would be able to use the

voucher to help pay for insurance plans of their choice. Many people believed that choice among insurance plans was good in itself. They held this view despite overwhelming evidence that people care much more about choice of providers than they do about choice of insurance plans—and no private plan gives more choice among providers than Medicare does. In any case, the hope of voucher advocates was that insurers would compete for business based on cost and quality of service to customers.

The voucher idea gained momentum during the mid-1990s after failure of the Clinton administration's health reform effort and as financial projections for Medicare Hospital Insurance deteriorated (see figure 1). With momentum came intensified scrutiny. That scrutiny identified serious risks from vouchers for the elderly and disabled. As a result, the term 'voucher' acquired a rather nasty aura, which persists to this day.

Back in the mid 1990s, I shared both the hopes of those who believed that vouchers could generate significant savings and the fears of those who believed that vouchers would expose Medicare enrollees to dangerous risks. So did my Brookings colleague at the time, Bob Reischauer. As economists, we recognized the appeal of consumer choice. We understood the power of competition to police price and quality if market conditions were favorable. But we also believed that many of the plans then under consideration suffered from serious shortcomings. And we were convinced that whether voucher plans would have a chance of success depended on details—that place where the devil famously resides—to which few people were paying much attention.

So, we proposed three modifications to voucher plans that would minimize those risks.[7]

- The voucher plans then under discussion were mostly linked to indices, such as the consumer price index or nominal GDP, that had grown more slowly than health care spending and were expected to do so in the future. Such vouchers would systematically shift costs to Medicare beneficiaries even if growth of health costs did not slow. To be sure, linking vouchers to these indices would surely cut growth of Medicare spending. That would be good for the budget, but bad for Medicare beneficiaries. We believed that health care subsidies should be cut if plans fostered real economies, but not otherwise. Accordingly, we argued, that the voucher should be linked to general health costs. If competition boosted efficiency, enrollees and the taxpayer would both gain. But if competition didn't boost efficiency, the first and overriding goal should be to protect the very vulnerable people who are enrolled in Medicare from increased financial burdens they could ill afford.

- The voucher plans then under discussion placed no limit on the number and variety of plans that insurers could offer. Few people have the capacity to evaluate the full range

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[7] Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What is the Next Step," *Health Affairs*, Winter, 1995, pp. 8-30.

of provisions that insurance plans routinely contain. We believed that if consumers were to have a chance at all to choose rationally, the range of plans had to be limited to a modest number of prototype plans. Insurers should compete on service and cost, not by befuddling customers with variations that they could not evaluate.

- Health care cost for the Medicare population are high and concentrated. Accordingly, insurers have powerful incentives under standard voucher plans to compete based on risk selection. Such competition is costly and, in a plan that covers everyone, it is also socially pointless. We urged that direct sales by insurers should be banned. Instead, all insurance sales to the Medicare population should be carried out through a private non-profit organization or a government agency, charged to provide objective information, advice, and counseling. We also said that no premium support plan should be considered until and unless a system of 'risk adjustment' was developed that was good to discourage insurers from competing via risk selection.

We christened a voucher plan that contained all three of these elements, including effective risk adjustment. We christened that system 'premium support.' The term had not previously been used, but rapidly came into widespread use. The National Bipartisan Commission on the Future of Medicare adopted it three years later. So have others. The name, 'premium support,' was and is often applied to plans that lacked one, two, or all three of the safeguards that we regarded as essential. My point, let me stress, is not a semantic quibble. The meanings of words in common use often change. But when a term is used in ways that obscure important policy distinctions, the misuse is harmful.

IV

John Maynard Keynes is alleged to have quipped: "When the facts change, I change my mind. What do you do, sir?" As time passed, circumstances with respect to health care policy in general and Medicare policy in particular have changed. With those new facts, my views of premium support have also changed.

While I would not go so far as to argue that premium support should never be considered for Medicare, I believe that there are overwhelming and persuasive reasons why it should not be enacted now. I also have become less confident that premium support, even if it works for the rest of the population, would be desirable for Medicare. But it is too early to be sure. That said, I believe that there are several changes to Medicare that should be made promptly. These changes would lower costs, improve quality, and enhance fairness. I shall mention a few briefly in the next section of my testimony.

Improved Financial Prospects. The Affordable Care Act has significantly improved the financial prospects of the part A trust fund. Even with the increased cost estimates in the 2012 Trustees Report, the cumulative deficit over the next quarter century could be closed by a payroll tax increase of just 0.35 percent each on workers and employers. It could also be closed

by changes in premiums, cost sharing or other program elements that achieved equivalent savings.. For Medicare as a whole, the Affordable Care Act has reduced by nearly half the anticipated increase in the program's cost as a share of GDP. The currently projected increase is 2.1 percentage points over the next quarter century. That increase is not trivial, but in my view, it does not come close to meriting characterization that Medicare is in crisis or that Medicare is unsustainable.[8]

Improved Backup Protection. The Affordable Care Act has not only directly improved Medicare financing, by raising revenues and reducing outlays. It has also created a back-up administrative safeguard, the Independent Payment Advisory Board. If growth of program outlays exceeds statutory targets, the IPAB is charged to design ways to hold growth of Medicare spending to those targets. The Congressional Budget Office believes that Medicare spending over the next decade will be within targets set in the Affordable Care Act and that the IPAB will not be required to act. But over the longer haul, this organization can help prevent Medicare spending from growing excessively. Congress is free to substitute alternative controls of its own design if it does not like the IPAB's recommendations. I believe that some changes in the IPAB's powers and organization could improve its effectiveness.

Health Insurance Exchanges. No plan that lacks aggressive regulation of insurance offerings and how they are sold merits designation as 'premium support.' No plan that lacks such regulation has any chance of enabling Medicare enrollees to make rational choices among plans, nor could it discourage competition based on risk selection. None of the plans now sailing under the premium support flag pays more than passing attention to this matter. None has drafted legislative language specifying how such regulation would be done.

As it happens, we are in process of designing health insurance exchanges. The Affordable Care Act invites states to create exchanges to regulate insurance offerings and sales to those who are not insured through work or through a public program. This effort shows that numerous practical and political problems must be solved in order to make these exchanges work. I have no doubt that these problems can be solved—and, with good will, they will be solved. But we do not yet know answers to some key questions. For example, we do not yet know whether state-based exchanges will work better than regional exchanges or a single national exchange. If the state exchange model is viable, we don't yet know which forms of exchange will work best.[9]

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8 Before enactment of the Affordable Care Act the Trustees Report projected growth of Medicare spending from 2010 through 2035 of 3.9 percentage points of GDP. The 2012 Trustees Report (p. 207) shows that Medicare spending will equal 3.72 percent of GDP in 2012, 5.73 percent of GDP in 2035 and 5.97 percent of GDP in 2040. The corresponding numbers from the 2009 Trustees Report were 3.6 percent in 2012, 7.23 percent in 2035 and 7.86 percent in 2040.

9 In numerous essays written for the journal *Health Affairs*, law-professor Timothy Jost has explored a wide range of important, difficult, and solvable problems relating to the health insurance exchanges and other issues that have to be addressed.

Furthermore, the population to be served by the Affordable Care Act is both smaller and easer to handle than would be the Medicare population. The enrollees in the ACA exchanges will be neither elderly nor disabled. Millions of Medicare enrollees suffer from various degrees of mental impairment. For that reason, the ability of the ACA population to process information will be superior to that of the Medicare population. Because the level and variance of health spending among the ACA population is far lower than are those of Medicare enrollees, incentives for insurers to compete based on risk selection under the ACA will be smaller than they would be if the exchanges also covered Medicare enrollees. Health insurance exchanges that will operate well with the ACA population may or may not be able to handle the Medicare population. ***To move ahead now to commit to enroll the Medicare population in entities that do not yet exist and whose capabilities have not yet been tested and proved would be a rash legislative act carrying the threat of hardship and disruption***. Only after the health insurance exchanges called for by the Affordable Care Act have been set up, only after the administrative problems they will doubtless confront have been solved, and only after we have some reason to believe that they will be able handle the much more challenging Medicare population—only then would it make sense for Congress to consider shifting Medicare enrollees to vouchers. *Even then, it will be of critical importance to understand that the frailties of a large part of the Medicare population may mean that insurance models that make sense for comparatively healthy working age Americans may not make sense for the elderly and people with disabilities*.

For similar reasons, the experience of the Federal Employees Health Benefit Plan provides little guidance one way or another to the desirability of giving Medicare enrollees a voucher and asking them to shop from a menu of competing private plans. The FEHBP population is better educated than the average American. Government agencies provide considerable information and enrollees have networks that enable them to guide each other to an extent that economically inactive retirees and people with disabilities do not possess. Most importantly, I am unaware of any evidence that the FEHBP has held down the *rate of growth* of health spending for its members below the growth of spending for the general population.

Change in Regulatory Climate. The role of government regulation has become vastly more controversial than it was in the 1990s. The kind of regulation of insurance offerings and marketing that I believe is a defining and vital element of premium support is simply unimaginable today. The political polarization around the matter of government regulation and the increasingly aggressive use of the filibuster in the Senate—which, I believe is a function of minority status, not party label—make it inconceivable that the sort of regulation necessary to make a market for health insurance genuinely competitive could win passage now or, if passed, be sustained. Without such regulation, in my view, the health insurance market under a voucher plan would likely be as deplorably inefficient as the non-group health insurance market is today. But the consequences would be far more serious—not just wasteful administration,

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http://healthaffairs.org/blog/author/jost/

and price distortions induced by adverse selection, but much worse, since the needs of the Medicare population are so large and insistent.

Failure of Risk Adjustment. A necessary element of successful competition under a voucher is effective risk adjustment. It is well known that health expenses are highly concentrated and are much higher, on the average, for Medicare enrollees than for the general population. Insurers who 'get stuck' with a lot of very sick people can lose a lot of money or even grow broke. Shareholders do not hire administrators to lose money or go broke. Accordingly, insurance administrators have a duty to the people who hired them to try to enroll healthier than average people. Of perhaps greater importance, they need to retain healthier-than-average enrollees. Because of these incentives, all competent health analysts have long recognized that, if premiums are uniform or vary less than expected cost, the key to a successful health insurance market is risk adjustment. Risk adjustment consists of financial transfers among insurers to offset the variations in expected health costs related to the characteristics of enrollees. Insurers that enroll people with comparatively low expected health care use would pay money to insurers that enroll people with high expected use.

In the 1990s, risk adjustment was inadequate. It was not then 'good enough to discourage competition based on risk selection. But it was getting better. I assumed, perhaps too facilely, that it soon would get 'good enough.' Well, to date it hasn't. Recent research has shown that the Medicare risk adjustment algorithm actually increased program costs by as much as $30 billion or 8 percent in 2006.[10] The problem is that risk selection increased along lines that were not included or could not be included in the risk adjustment formula. Plans have available many ways to attract customers expected to have low costs ("the X health plan is offering a free golf weekend"). They can also use the quality and availability of services to discourage high cost enrollees from remaining ("we are sorry, but our oncologist is booked solid for the next six weeks; no, he is the only one on staff"). They can also take steps to encourage low-cost enrollees to stay ("all current enrollees who remain in our plan will receive a free gym club membership"). The challenge of defeating such behaviors is never easy. But in an atmosphere hostile to aggressive regulation, it is impossible, particularly when the stakes are as high as they are with the Medicare population, whose costly patients are very costly indeed.

Medicare Competition Exists—the Results are Disappointing. To believe that competition does not exist in the Medicare program and that one must shift all enrollees to vouchers to create such competition is simply false. Medicare Advantage exists. It enrolls a quarter of all Medicare beneficiaries. It is well established. By 2010, the average Medicare enrollee could choose among an average of 24 plans, in addition to traditional Medicare — 10 health maintenance

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[10] Jason Brown, How Does Risk Selection Respond to Risk Adjustment? Evidence From the Medicare Advantage Program, NBER Working Paper No. 16977, April 2011. http://www.nber.org/papers/w16977

organizations, 4 local and 5 regional preferred-provider organizations, 4 private fee-for-service plans, and 1 cost plan.[11]

Enrollments in Medicare Advantage plans have fluctuated with the generosity of payments to them. In some years MA plans have been paid more per enrollee than average costs in traditional Medicare—14 percent more in 2009. At such times MA enrollments have risen because MA plans could offer extras that Medicare beneficiaries value. When payments have been cut back, enrollments have fallen.

Fluctuating enrollments say nothing about whether competition from Medicare Advantage has lowered the cost of care. To answer that question, on needs to control for both the extra payments that MA plans have sometimes received and the extra services beyond the standard Medicare benefit package that they may provide. After one has adjusted for these factors, as well as enrollee characteristics, have Medicare Advantage plans been able to deliver the standard benefit package at lower cost than has traditional Medicare?

Until recently data to answer that question were unavailable. Thanks to a Freedom of Information Act suit, the relevant data are now available and the results are in. On average, Medicare advantage plans cost 3 percent more in urban areas and 6 percent more in rural areas than does traditional Medicare.[12] That is far from the end of the story, however. Relative costs vary enormously. MA plans are less costly than traditional Medicare in counties where roughly 30 percent of Medicare beneficiaries live. FFS plans are less costly than MA plans in counties where roughly 70 percent of Medicare beneficiaries live. One might suppose that where MA plans are comparatively cheap, a larger share of Medicare enrollees would choose them than in areas where FFS plans are comparatively cheap. To my surprise, no such pattern seems to exist. The lack of such a pattern dampens hopes that 'cost conscious consumers' will be the driving force for holding down health care spending.

Those who hope that providing Medicare beneficiaries with vouchers will help control costs often point to the fact that the costs of the Medicare drug benefit have come in far below pre-enactment estimates. Unfortunately, this claim does not withstand scrutiny. Events that are largely or totally independent of enactment of the Medicare drug program have caused ***total*** expenditures for drugs to fall short of estimates made in 2003 when Congress was debating the program. One of those events, the fall-off in the introduction of new 'block-buster' drugs, is

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11 Marsha Gold, et al., "Medicare Advantage 2011 data spotlight," Washington, DC: Kaiser Family Foundation, October 2010. (Publication no. 8117. http://www.kff.org/medicare/upload/8117.pdf

12 Brian Biles, Giselle Casillas, Grace Arnold, and Stuart Gutterman. "Medicare Private Plan costs and Medicare Fee-for-service Costs: Do Private Plans Cost Less than Medicare Fee-for-services?: new Findings from New Data," 26 September 2011; Brian Biles and Giselle Casillas. "Medicare Advantage Plan Costs and Medicare FFS Costs: Beneficiary Weighted, July 2009 Data," 10 April 2012. Provided by bbiles@gwu.edu.

hardly a cause for celebration. New drugs have brought benefits even larger than their costs. The other trend—the growing use of generics—has been good news. The Medicare drug program may have accelerated the shift to generics and, thus, deserve some credit for the trend. But the simple fact is that Medicare part D costs have been lower than was estimated by a bit less than the cost of non-Medicare drugs have been below estimates made at the same time.[13]

In any event, drug costs are not the only criterion for evaluating Medicare part D. Of equal importance is whether enrollees in Medicare part D choose the plans that best meet their needs. Recent research suggests that they do not. By over-weighting premium costs relative to protection against risk, enrollees are choosing plans that do not provide them optimal protection.[14] They could improve their own welfare by choosing plans that cost a bit more up front, but provide more protection against heavy drug needs.

Erosion of Benefits. Many years ago, when Bob Reischauer and I floated the premium support idea, friends who supported traditional Medicare warned that vouchers, with or without our proposed safeguards, were a bad idea. Vouchers, they warned, are subject to erosion in a way that a defined-benefit plan is not. It is politically harder, they argued, to chop off a specific medical benefit—say, by limiting access to skilled nursing facilities or by capping the number of doctors visits permitted each year—than it is to shave a voucher. Which is more difficult is, of course, a matter of political judgment. But the many positions taken by the chairman of the House Budget Committee give me pause. Mr. Ryan has supported plans that would tie the value of vouchers, variously, to the growth of gross domestic product plus 1 percent (in proposals put forward jointly by Mr. Ryan and both Senator Ron Wyden and my colleague, Alice Rivlin), to the growth of gross domestic product plus ½ percentage point (this years Budget Committee proposal), or the consumer price index (last year's budget proposal). The implications of these proposals over a period of many years are vastly different because of the inexorable force of compound interest. Even if one were prepared to disregard the many other elements that would—or should—go into a serious premium support plan, the 'principle' involved in plans with such widely divergent adjustment formulas is so elastic that there is, in fact, no core principle at all.

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The Medicare program has succeeded in its fundamental goal of bringing standard care to vulnerable populations. It has innovated in designing new payments systems. It promises to be something of a hammer in forging reforms in the health care payment and delivery system.

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13 Edwin E. Park, "Lower-than-expected Medicare drug costs reflect decline in overall drug spending and lower enrollment, not private plans." Washington, DC: Center on Budget and Policy Priorities, 6 May 2011 http://www.cbpp.org/files/5-6-11health.pdf.

14 J. Abaluck and J. Gruber, "Choice inconsistencies among the elderly: evidence from plan choice in the Medicare Part D program," *American Economic Review*, 2011;101, pp. 1180-210.

And it has delivered care at costs that are a bit lower than have competing private plans. Still, adjustments in the Medicare program can improve its operation. Given the purpose of this hearing, this is not the place to examine those changes in great detail. But I will list a few.

1. The Medicare Modernization Act shifted payment for drugs for dual eligibles from Medicaid to Medicare. The hope was that private pharmaceutical benefits managers would negotiate well enough to hold down costs. They haven't. The result instead has been a sharp rise in the cost of providing drugs to dual eligibles. Various commissions and the president have proposed changes that would recapture all or most of those savings. The savings would exceed $100 billion over ten years.

2. The announcement of these hearings correctly pointed out that Medicare retains a structure common in 1960s private insurance. Combining parts A and B would have certain advantages. That said, simply imposing a single deductible and single cost sharing formula for both parts would boost costs for most enrollees, many of whom have very low incomes and can ill afford higher premiums. It would also violate the principles of value-based insurance design. While change is desirable, the form that change should take remains unclear. While change in the part A/part B structure is desirable, its exact form remains to be designed.

3. Medicare spends too little on administration. With a larger administrative budget, Medicare could do a better job of rooting out fraud and save the taxpayers far more than the small increase in the enforcement budget costs. Similarly, when Medicare approves a new procedure or treatment for specified situations, it now has too few administrative resources to make sure that guidelines are used. The result is overuse of new treatments in situations where approval is not granted and where evidence of effectiveness is lacking. Current restrictions on the CMS administrative budget are penny-wise economies that cheat both the taxpayer and Medicare enrollees.[15]

Conclusion

The U.S. health care system badly needs reform. Our payment system rewards quantity rather than quality. We waste huge sums on administration and at the same time neglect administrative outlays that could lower spending and increase quality. Medicare is part of that system and therefore is infected by many of those problems. But the problems of the U.S. health care system are not confined to or disproportionate in Medicare. Attention should focus on systemic reform. The Affordable Care Act has started us on that effort. That law is not perfect. In the course of its implementation we will learn a lot and encounter unanticipated effects that will cause us to change the law. But the successful implementation of health

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15 Robert A. Berenson and John Holohan, "Preserving Medicare: a practical approach to controlling spending: timely analysis of immediate health policy issues,". Washington, DC: Urban Institute, September 2011 http://www.urban.org/uploadedpdf/412405-Preserving-Medicare-A-Practical-Approach-to-Controlling-Spending.pdf.

insurance exchanges is a necessary precondition for serious consideration of a voucher system. To bull ahead with a voucher plan of any stripe, before we have in place health insurance exchanges, an essential element if such a plan is to succeed, would be rash and irresponsible.

Chairman HERGER. Thank you, Mr. Aaron.

Senator Breaux, I think it is important to get this out of the way right at the beginning of this hearing. Do you think premium support will "end Medicare" as we know it as some have claimed?

Mr. BREAUX. I think the whole debate politically about ending Medicare as we know it, I think we want to change Medicare. We want to keep Medicare. I think we want to improve the delivery system. I think everybody is committed to having the Federal Government provide adequate quality health care for our Nation's seniors. But we don't have to do it under a delivery system that was formed in 1965. Just like my Chevy II, things have changed, things have improved, so our recommendation is that we keep Medicare of course, it is a great program, but change the way it is delivered to our Nation's seniors so they get a better deal, a better product at a better price.

Chairman HERGER. So then you would say that premium support does have the potential to improve the Medicare program and shore up its long-term finances by harnessing private sector innovations?

Mr. BREAUX. My answer would be yes, but you don't have to take my word for it. Look at the things we have done in the areas where we implemented premium support. Medicare Part B is a classic premium support system. The government helps pay for it, and they help set it up with the private sector competing for the right to deliver the product. Let me suggest it is a program that is more popular today than the Congress that wrote it, and I include myself in that group because I was there. The seniors love it.

Second, the second example is even better, every one of us up there and me have a premium support Federal Employees Health Benefits Plan, that is a classic premium support. People can choose from, they can continue fee-for-service if you want to stay there, but the Federal Government sets up a premium support. We have the Office of Personnel Management guaranteeing that everybody that participates can deliver the product and negotiate for the price. That combines the best of what government can do with the best of what the private sector can do. So don't take my word, look at the two times we were able do this, and I would think you would agree it works very well.

Chairman HERGER. Mr. Antos, I think it is important for all of us to focus on what the Medicare program is facing today. The Medicare trustees released their 2012 report just this week. When do you expect the Medicare hospital insurance trust fund to go bankrupt?

Mr. ANTOS. Well, I rely on the trustees, who are the Secretaries of Treasury, Labor, HHS and two public trustees, and they rely on Mr. Foster, who is the Chief Actuary. If current law is actually implemented, which means major cuts in payments to hospitals and other Part A providers, then their projection is that the Part A trust fund will run short of funds by 2024. However, under other assumptions it would be much earlier than that. And in fact under the so-called high cost assumption that the trustees also present, it is 2016.

Chairman HERGER. So even with the projections that we were to make these major cuts, which most dealt very much we would make to hospital, what with the bankruptcy—you say 2024, what was the bankruptcy date in last year's Trustees' Report?

Mr. ANTOS. 2024. So some people say that we've held our ground. Another way to look at it is we are 1 year closer.

Chairman HERGER. In other words, we are 1 year closer, as you mentioned, to this looming, addressing this looming problem.

The trustees stated that Congress and the executive branch "must work closely together with a sense of urgency." In other words, now is the time to address significant reform of the Medicare program.

Do you agree with this assessment?

Mr. ANTOS. Yes, sir, it is absolutely vital.

Chairman HERGER. Ms. Rivlin, the plan you worked on with Senator Domenici is similar to the 2013 House passed budget as private plans that compete against traditional fee-for-service Medicare.

Can you please explain how this competition will control costs, not only for the beneficiaries enrolled in the private plans but also for traditional Medicare?

Ms. RIVLIN. Yes. On a structured exchange where you can really see, where the consumer can really see what the choices are, the plans that participate would offer their wares and they would have to agree to take everybody who wanted to join their plan and to give actuarially equivalent benefits to fee-for-service Medicare and they would be competing directly with fee-for-service Medicare. There are lots of new innovations in how you treat people, including people with chronic diseases and there is evidence that plans can offer better services and bring down the cost of treating Medicare beneficiaries. We believe that would happen and that through the bidding process the cost of the plans would maybe not come down, but not increase as rapidly as they otherwise would. And that fact that the government contribution would be slowed would be of benefit to everybody, including those in fee-for-service Medicare.

Chairman HERGER. In other words, quality could be higher, service could be higher, but the cost could be more?

Ms. RIVLIN. Yes, we think that would be true. Fee-for-service Medicare would compete and would probably get better over time because otherwise people would leave it. But there is a lot of evidence that fee-for-service doesn't coordinate care very well. I am a Medicare beneficiary. I watch this happening and the coordination among providers is terrible. If you are looking at comprehensive capitated plans, whose responsibility is to take care of everybody in that plan, you are likely to get better results.

Chairman HERGER. Thank you very much. Mr. Stark is now recognized for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman. Mr. Aaron, would the Medicare Trust Fund become insolvent sooner under the Republican plan to repeal ACA?

Mr. AARON. The ACA contained many provisions that extend the life of the Medicare Trust Fund. It was a major improvement in the financial status. There can be—is grounds for legitimate de-

bate about whether every element of the ACA is going to be enforced down the road, but there are additional revenues and a host of payment reforms that are designed to lower cost with scorable savings and others that while not scored by CBO contain virtually every idea for payment reform that analysts have come up with.

Mr. STARK. I have a letter from CMS that indicates that without the ACA the trust fund would expire 8 years earlier, and I would ask the chairman to make that letter a part of the record.

Chairman HERGER. Without objection.

[The letter from CMS follows: The Honorable Pete Stark]

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Medicare Stable, But Requires Strengthening

The Medicare Trustees Report released today shows that the Hospital Insurance (HI) Trust Fund is expected to remain solvent until 2024, the same as last year's estimate, but action is needed to secure its long-term future. In 2011, the HI Trust Fund expenditures were lower than expected.

Without the Affordable Care Act, the HI Trust Fund would expire 8 years earlier, in 2016. The law provides important tools to control costs over the long run such as changing the way Medicare pays providers to reward efficient, quality care. These efforts to reform the healthcare delivery system are not factored into the Trustees projections as many of the initiatives are just launching.

"The Trustees Report tells us that while Medicare is stable for now, we have a lot of work ahead of us to guarantee its future," said Acting CMS Administrator Marilyn Tavenner. "The Affordable Care Act is giving CMS the ability to do this work, with tools to lower costs, fight fraud, and change incentives so that Medicare pays for coordinated, quality care and not the number of services."

The report projects that the Supplementary Medical Insurance (SMI) Trust Fund is financially balanced because beneficiary premiums and general revenue financing are set to cover expected program costs. Spending from the Part B account of the SMI trust fund grew at an average rate of 5.9 percent over the last 5 years.

SMI Part D, the Medicare prescription drug program, had an average growth rate of 7.2 percent over the last 5 years. Cost projections for Part D are lower than in the 2011 Trustees report, due to lower spending in 2011 and greater expected use of generic drugs.

HI expenditures have exceeded income annually since 2008 and are projected to continue doing so under current law in all future years. Trust Fund interest earnings and asset redemptions are required to cover the difference. HI assets are projected to cover annual deficits through 2023, with asset depletion in 2024. After asset depletion, if Congress were to take no further action, projected HI Trust Fund revenue would be adequate to cover 87 percent of estimated expenditures in 2024 and 67 percent of projected costs in 2050. In practice, Congress has never allowed a Medicare trust fund to exhaust its assets.

The financial projections for Medicare reflect substantial cost savings resulting from the Affordable Care Act, but also show that further action is needed to address the program's continuing cost growth.

The Medicare Trustees are Treasury Secretary and Managing Trustee Timothy F. Geithner, Health and Human Services Secretary Kathleen Sebelius, Labor Secretary Hilda L. Solis, and Social Security Commissioner Michael J. Astrue. Two other members are public representatives who are appointed by the President, subject to confirmation by the Senate. Charles P. Blahous III and Robert D. Reischauer began serving on September 17, 2010. CMS Acting Administrator Marilyn B. Tavenner is designated as Secretary of the Board.

The report is available at: https://www.cms.gov/ReportsTrustFunds/downloads/tr2012.pdf

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Mr. STARK. If we had vouchers, or whatever you want to call premium support things, the Medicare would stop being a defined benefit plan and become a defined contribution plan, would it not?

Mr. AARON. That is exactly what I meant in my opening comment about who bears the risk if costs rise more than are anticipated.

Could I inject one comment which I think is important?

Mr. STARK. Please.

Mr. AARON. The statement has been made a couple of times that Medicare is the same as it was 47 years ago, that just isn't true.

Mr. STARK. You are right, I remember the change.

Mr. AARON. It has evolved in a number of very important ways. It has pioneered in payment reform with the DRG system with respect to payment. And as various people have noted, it does contain in one form or another, we may like it or not, the options for individuals to choose among a large number of competing private plans.

Mr. STARK. I have always suspected it was Republicans, but you know these guys who march outside with the billboards over them saying the world's going to come to an end. They have now crossed that out and say that Medicare is going to come to an end in 2024 or whatever—12 years. I can remember when those signs said it was going to end in 1 year. And I can remember years when the trustees report said we had 20 years.

But the fact is that to change the existing—the life of Medicare costs relatively so little to the population at large, I believe that the figure to extend the solvency of Medicare beyond the 75-year target that people have talked about would cost less than say a 3 percent total increase in the premiums or lifting the cap or doing a host of those types of things, so that it hardly seems unless you so strenuously object to anything that sounds like a tax or a fee, which many of my colleagues do, but if you are willing to ask the public who will benefit from this plan to pay a reasonable amount over their lifetime, I see no reason that it can't be extended forever without hurting job growth or putting the country further into deficit. Does that make sense to you?

Mr. AARON. Yes, it does, but I would modify it in one direction. I haven't a clue what is going to happen in the health care world in 50 or 75 years. What is science going to produce, what will be the impact on longevity? In my view, trying to look 50 or even 75 years ahead, with respect to health care, pensions are different, with respect to health care in my view is a fool's game. And it was a bad day when the actuaries were required to look 75 years ahead in the case of health care. Look 25 years ahead, that is quite a long time and there is a lot of uncertainty within that. Over that period you could close the Part A trust fund gap with an increase in payroll taxes of .35 percent each on workers and employers, or more cost sharing on some Medicare beneficiaries, or additional payment cuts through what we would hope backed up by improvements in delivery, which is one of the goals of the Affordable Care Act.

So I think the idea that Medicare is standing on the brink of a dangerous precipice for as far ahead as it is reasonable to look is simply incorrect.

Mr. STARK. Thank you. The 75-year target doesn't bother me much, but I will come back and ask Mr. Herger, he will find out what it is like. Thank you, Mr. Chair.

Chairman HERGER. Well, I would agree to a degree we have a tough time estimating what is going to happen next year, let alone 5 years, 25, 75 years, but one thing we do know, 10,000 Baby Boomers are now going on Medicare every day and that is something we are aware of. And again we have to hopefully in a bipartisan way work together to solve this so it does remain stable for our children and our grandchildren.

With that, Mr. Ryan is recognized.

Mr. RYAN. Thank you, Mr. Chairman. You know, I hesitate to say this, but, Dr. Rivlin I think I agreed with everything you said in your opening statement. And the reason I hesitate is every time I say something nice about a Democrat it gets them in trouble, they get viciously attacked. So in light of Mr. Stark's opening statement and comments, I am considering making really nice comments about you. See if I can direct it over from Alice to you. So I will be working on that.

Look, there seems to be this attempt to undermine premium support and how it came to be. Let's remember that it started as a Democratic idea. We have the grandfather of the original idea here, the author in Congress of its last iteration here. And so there is clearly room for the two parties to talk to each other about this issue. If we could just calm down a little bit, we might be able to save this program.

Recently I worked with Ron Wyden. I know that is a name. I probably got him in trouble right there saying that.

Here is what Ron Wyden tells me—first of all I think if we want real lasting Medicare reform in my judgment it does have to be bipartisan. So here is what a Democrat, Ron Wyden, tells me: Democrats can't support a proposal that does not have an ironclad Medicare guarantee. It must maintain traditional fee-for-service as a viable option. It needs to guarantee affordability for the Medicare consumer and protect the low-income. It must have strongest consumer protections for seniors and aggressive risk adjustment to protect the marketplace.

So this is what a Democrat in good standing and Member of the Finance and Budget Committee in the Senate tells me are sort of the essential principles for premium support to move forward.

That seems hardly irrational to me. That, to me, strikes me as these are ideas we should talk about with each other and there is plenty of room for conversation with one another, and we ought to have that conversation. So I think we need to put this in perspective.

This is a program that is going bankrupt. We have the actuary come here all the time, whether it is the Budget Committee or the Ways and Means Committee, telling us providers are going to leave the system, they are going to stop seeing Medicare beneficiaries, the trust fund is going bankrupt. All those things are known to us now, and it is just so much smarter given that 10,000 are retiring every single day to get ahead of this problem and prepare the program so that it can be a guarantee that is not only there for today's seniors, but for tomorrow's seniors.

There is one thing, Dr. Rivlin, that you convinced me of from all our conversations over the years on this, that we modified our plan for this, and that is competitive bidding. It seems to me a far smarter way to set the rate system. Give me a quick synopsis of why competitive bidding is superior, what are the attributes to it, and how you propose to set it up, the second lowest plan bid and the like?

Ms. RIVLIN. Yes. I think competitive bidding among plans, including fee-for-service Medicare, in a regional exchange, and by "regional," we mean a metropolitan area or a large rural area, how this would work is the plans would offer their plan and bid on the opportunity to serve Medicare beneficiaries with the same benefits. And the second lowest bid would determine the government contribution. If you chose the lowest bid plan, you would get the money back. If you wanted to go higher up the scale, you could. You could choose a more inefficient plan or one that offered additional benefits for higher cost.

But most people would look at how can I get these benefits at a cost that I can afford. And the government contribution at the second lowest bid would then mean if you are in fee-for-service Medicare, you would have the option, if that plan was higher, of moving to one that cost you less and getting the same benefits.

There would be parts of the country where the fee-for-service plan might be the best plan and you could stay there, or other people in other plans could move there. But it seems like a good bet for offering seniors comprehensive services at the best possible price.

Mr. BREAUX. Can I add something just really quick to that, Congressman Ryan. And that is the point that in some rural areas you may not have competition, so you have to take steps to protect rural areas where there may not be any competition. And we did that in Breaux-Frist by saying that no beneficiary would have to pay more than the current Part B premium for his standard plan. So you can take care of those areas where there may not be sufficient competition to really create a competitive model.

Mr. RYAN. Five minutes goes fast. Thank you.

Chairman HERGER. Thank you. Mr. Gerlach is recognized for 5 minutes.

Mr. GERLACH. Thank you, Mr. Chairman.

Dr. Rivlin, looking at your testimony and specifically quoting you to say I believe a well-crafted bipartisan bill that introduces a premium support model while preserving traditional Medicare can help achieve these goals, and then you go on to say that the Domenici-Rivlin proposal is very similar to the bipartisan proposal presented by Chairman Paul Ryan and Senator Ron Wyden in December of 2011.

So as a result of that testimony, I would take it then you consider the Ryan-Wyden plan to be a premium support plan, is that correct?

Ms. RIVLIN. Yes, I do.

Mr. GERLACH. Okay. And since the Ryan-Wyden plan was incorporated into the House Republican budget and passed a few months ago, therefore that plan as passed by the House is a premium support plan, is that correct?

Ms. RIVLIN. Yes. I think there are some differences between the plan put in the budget. A budget resolution is just a budget resolution. It isn't a draft of a Medicare law.

Mr. GERLACH. Correct.

Ms. RIVLIN. So it is a bit elliptical. And I would stick with my statement that I support Ryan-Wyden.

Mr. GERLACH. As I think of the word "voucher," I think of a situation where government would provide a payment to a private citizen, either cash or some sort of check form of payment, and that citizen would take that and then purchase a product or a service with that money received from the government. Is that a typical or rational definition of what a voucher is?

Ms. RIVLIN. That is what a voucher means to me, and premium support as we define it is definitely not a voucher. You don't get a check from the government, you get a choice among plans and the plan gets a risk-adjusted payment, a payment that reflects your age and health condition. And you don't even know what that is as the individual bidder, as the individual beneficiary. That is between the government and the plan.

Mr. GERLACH. So the Domenici-Rivlin proposal was not a voucher program, correct?

Ms. RIVLIN. No, it was not a voucher program.

Mr. GERLACH. And the Ryan-Wyden proposal was not a voucher program.

Ms. RIVLIN. Not as I understand those terms. No.

Mr. GERLACH. Thank you so much. I yield back.

Chairman HERGER. Thank you. Mr. Thompson is recognized.

Mr. THOMPSON. Thank you, Mr. Chairman, and thanks to all the witnesses for being here.

I am a little heartened actually. There seems to be a lot of agreement. Everybody agrees we need to fix Medicare, we need to make it work, and so that is the best news I have heard on this topic for a long time.

I would submit, Mr. Chairman, that it might be helpful as we are looking at this if we had a plan in front of us. We have heard a lot of criticism about Mr. Ryan's plan. We have heard criticism about the Ryan-Wyden plan. We have heard those who are proponents of that suggesting that maybe it is not what the critics say it is. It would be good if we had a plan. We could actually see the details of that plan and be able to get down in the weeds and look at it. Until that happens, we are just going to maybe be spinning our wheels.

But I do know a couple things for sure. I know that as I travel my seven county district, that includes both rural areas, Senator Breaux, as well as urban areas, I hear a lot from the people that I represent about Medicare and what they think about Medicare. And I hear them tell stories juxtaposing the Medicare they have today vis-à-vis what their parents or grandparents had, and it is clear, and I hear it all the time, they like what they have now with Medicare. They like that.

Now, I hear criticism of Medicare. I hear people say don't cut my benefits, and I also hear people say keep your government hands off my Medicare, which is one that I always kind of chuckle at, because I guess everyone hadn't gotten the memo yet that Medicare

is, in fact, a government program. But I have never heard anybody say please, please, go to a voucher system, do away with my defined benefit program. And I don't think I am in the minority there. The Kaiser Family Foundation did polling on this, and I think 70 percent of the people agree with that.

I think we really need to keep in perspective the fact that providing health care to seniors and to people with disabilities isn't a huge money maker. It is not a huge money maker. And I think that it is important that we note, and I am glad that Mr. Antos pointed out the fact that he puts great belief and credit in what the trustees say. I want to reiterate what Mr. Stark said. The trustees just said that accountable CARE Act lengthens the life of Medicare by 8 years, and the CBO has said that if we put in place my friend Paul Ryan's proposal, they project that the total health care spending would grow faster under that proposal and for the typical 65-year-old, there would be an increased cost between 50 and 66 percent.

Mr. Aaron, could you comment on the effects to society of health care spending growing that fast and what would it do to the, not only health care, but to the greater economy?

Mr. AARON. I don't think there is a lot of difference among the four witnesses on the fact that rising health care costs are a problem in this country. They squeeze public budgets, they squeeze private compensation. For that reason, systemic health care reform is the key to moving ahead. I think there is a serious risk of trying to screw down on the costs of just one element, even a large and significant element such as Medicare, while not attending to the rest of the health care system.

For that reason, I think that the key now, the most important thing to do now is to move ahead with systemic health care reform. The law of the land is the Affordable Care Act. Nobody I think regards that law as perfect in every way. We are going to learn new things as it is implemented and we will probably change it down the road.

But the first job is to make, to the best of our ability, to make that system work. To the extent that we do that, we then should, in my view, be open minded and willing to come back in future years and consider whether changes such as the ones that are being proposed here today should be enacted and implemented. But I think now is not the time to do that.

Mr. THOMPSON. Thank you. My time is expired. I yield back.

Chairman HERGER. I thank the gentleman, and I just would like to emphasize that as our witnesses pointed out, the trust fund is going bankrupt in 2024. The trustees indicated it was going bankrupt in 2024 last year. That means we have 1 year less than we did a year ago. So this is something the sooner we begin on a bipartisan manner working on this, and not using hopefully scare terms like "voucher." I don't know of anyone except a few people on the other side that are using that term. The purpose of this hearing is to talk about premium support, which is a bipartisan suggestion on how we might be able to fix the system and preserve it. So I would just like to make that point.

With that, Dr. Price is recognized.

Mr. PRICE. Thank you, Mr. Chairman, and I want to commend the chairman for holding this hearing, and I want to also recognize and commend the chairman of the Budget Committee, Mr. Ryan, for his work within our conference in educating people about the need for reform, but also the positive nature of premium support.

I also want to thank each of the panelists. You all have put really a life's work into many things, but not the least of which is positive suggestions and reforms for our health care system. As a physician, I can tell you that folks are hurting out there, not just patients and not just doctors. There are real challenges in the current system that we have.

By way of clarification and to make certain that folks understand that our proposal is a guaranteed proposal for seniors, it is stated in all of the communication that we have. It is also stated in the legislative language. It is a guarantee. So seniors need to appreciate that what we are trying to do is save and strengthen and improve Medicare in a positive way.

There has been some talk about what is Medicare going to look like in 25 years, in 75 years, what the finances are going to be. I want to share with you just what the current system looks like out there in the real world.

The status quo is clearly unacceptable. There are new Medicare patients. We talk about 10,000 folks reaching retirement age or getting on Medicare every single day. If you are in a community and you are currently a non-Medicare patient reaching Medicare age tomorrow, and you are currently being seen by a physician who does not see Medicare patients, the challenge that you have in finding a doctor to see you as a Medicare patient is huge. The difficulty of new Medicare patients to find a physician seeing new Medicare patients is massive.

The physicians out there are going crazy with this current system. It doesn't make any sense at all, and it is more and more onerous, more and more difficult to be able to just care for patients. One out of every three physicians in this country limits the number of Medicare patients that they see. One out of every eight physicians in this country sees no Medicare patients at all. That is not a system that works. So we need to find a positive solution, which is what we have been trying to put forward on our side of the aisle.

Ms. Rivlin, I was encouraged by the tenor of your testimony and commend you for the work that you have done in the area of premium support. You mentioned that your proposal differs some from the Ryan-Wyden proposal, and when I got to that area of your testimony, which wasn't in your spoken testimony but was in your written testimony, one of the areas that you differ with the Ryan-Wyden proposal is that you believe we can move to a premium support system for seniors sooner than is in our proposal. Is that correct?

Ms. RIVLIN. That is correct.

Mr. PRICE. And would you expand on that? Our concern was that if we didn't what we call grandfather the grandfathers, that we would not only take political heat, but the challenge of moving in that direction that quickly would be too great. Please help me understand why you think we can move there sooner?

Ms. RIVLIN. Because we preserve traditional fee-for-service Medicare as the default option. I mean, it does grandfather anybody who is in it, and it is a permanent option. If you reach that age you are in it, unless you opt into something else. And we believe that the changes that would take place in the competitive bidding are substantial challenges, but they could be met by, say, 2018. We will have some experience in setting up exchanges under the Affordable Care Act by then, and there is no reason not to start sooner and let everybody have a choice.

You can view this as an improvement on Medicare Advantage that makes the competitive bidding—introduces competitive bidding and makes Medicare Advantage more accessible and better, and if you do it that way, it is not such a big deal.

Mr. PRICE. I want to thank you for that. And we will go back and scrub our numbers, but I want to thank you for what hopefully will be the genesis of a new found bipartisan opportunity to move forward and save and strengthen and improve Medicare by providing for those choices, but guaranteeing that seniors have the option of remaining on the current Medicare.

Thank you, Mr. Chairman.

Mr. STARK. Would the gentleman yield? I happen to be a fan of his bill to get rid of this idea that if a physician doesn't take Medicare, they are out of the system for 2 years. I join with him in trying to see that we get that changed, because that doesn't help anybody. You are to be credited for seeing that and trying to change it. Thank you very much.

Mr. PRICE. Thank you, Mr. Stark. I may fall into the category of Mr. Ryan, though. If I start saying nice things about you, we may all be in trouble. Thank you very much.

Chairman HERGER. Mr. Kind is recognized.

Mr. KIND. Thank you, Mr. Chairman, and thank you for holding this hearing. And I want to thank the witnesses for your testimony here today.

Senator Breaux, this is always a delight to hear you and your comments. But just for the record, I still have a '68 Chevy Malibu convertible that I love to drive around. And it is one of those cars where you can get under the hood and do your own tune-up and oil changes, and you don't have to be a computer whiz to do it. And my guess is that if you asked the typical senior in Medicare, they feel kind of comfortable with the Medicare system right now, and they think it is essential to the quality of their life. They want to see improvements made, but they also don't want to see it decimated.

I am one of those dwindling breeds here apparently in Congress these days, a moderate, centrist Member of Congress trying to find different pathways forward, hopefully in a bipartisan fashion, to address the challenges of our time, and I can't think of a bigger challenge than the dysfunctional health care system and the impact it is having not only on people's lives, but on our budget and our national finances.

I have been encouraged listening to a lot of your testimony because there appears to be a lot of agreement on the panel today that a lot of the tools that we put in place in the Affordable Care Act need time to move forward. Delivery system reform, so we get

better integrated, coordinated care leading to better outcomes; payment reform so it is value-based, not volume-based.

In a lot of respects, this hearing and this discussion we are having is premature, and Mr. Aaron and I agree. I think the Affordable Care Act needs a chance to move forward to see if this stuff works before you can actually have a serious conversation about a voucher or a premium support plan, and who ultimately is going to bear that risk.

But I have always been interested in just three things when it comes to health care reform: Better quality of care for a better bang for the buck, and making sure that all Americans have access to that type of care in this country. And how we get there is something that we have to continue to talk about.

But one of my concerns with the Republican budget proposal and their voucher or premium proposal is the risk in and who is going to bear it. But a bit of a parochial concern that I have from the State of Wisconsin, we have traditionally historically been one of the lowest Medicare reimbursement States in the entire Nation. We share that with the Pacific Northwest and some other regions. And under their proposal, apparently the rates will get locked in at the lower of either the current fee-for-service reimbursement rate, or the second lowest plan in that region, which would guarantee in Wisconsin that our providers are locked in at the lowest Medicare reimbursement rate, which they are struggling to live under today, which tells me that they are going to have to continue to cost shift the inadequacy of Medicare reimbursements on to the backs of businesses large and small, on to the backs of private health care plans.

Mr. RYAN. Will the gentleman yield?

Mr. KIND. In a second, so I can make my point.

This will not only continue the death spiral that our health care providers are experiencing in the State of Wisconsin, but the death spiral that businesses in Wisconsin are facing with rising health care costs because of the cost shifting that is currently impacting them, making it harder for them to compete, not only at home, but globally. And it does not make sense that we go down this road, not until at least we find out whether delivery system reform and payment reforms actually have a chance of working.

I have tried in my way to work in a bipartisan fashion in this Committee. Mr. Aaron, you pointed out that it is crucial that these exchanges have a chance to move forward and show whether or not they are viable or not. I have been the author in previous years of the SHOP Act, which was the basis for these health insurance exchanges, and every year I introduced that proposal, I had an equal number of Republicans and Democrats on that bill. We put it in the Affordable Care Act and my Republican colleagues ran for the hills.

I was one of the authors with Mr. Blumenauer on reimbursing our health care providers for counseling on advance directives. And every year we introduced that bill, we had at least five or six Members of the Committee, Republican Members, who were on that legislation. That was put in the Affordable Care Act and that turned into "death panels" and my Republican colleagues ran for the hills. So having that bipartisan conversation is difficult to have when

you have principles or issues that we had previously agreed on that suddenly divide us today.

I agree with Mr. Thompson, Paul, that to have a serious conversation, we need a plan. We need words on paper so we can actually see, because we all know, and I think everyone on this panel would agree, that the devil is in the details on how any type of premium support or voucher plan is ultimately structured. And we don't have that.

I talked to Ron Wyden too, and sometimes I feel like I am talking to two different people who are embracing the same type of plan. What Paul understands what the plan would mean, and what Ron Wyden understands sometimes they are talking past each other.

So unless or until you put something on paper so we can truly analyze the impact of this what this is going to mean, all this is theoretical.

Mr. RYAN. If the gentleman would just yield kindly, I will send to you and Mr. Thompson the plan that Senator Wyden and I coauthored with our signatures, and I will send it over to your office.

Mr. KIND. All right. But, again, I think, Mr. Aaron, I hear from you, and John, I think you testified too, that it is important that these delivery system and payment reforms as part of the Affordable Care Act right now have a chance to continue to move forward. And if, for some reason, the Supreme Court or this body decides to overturn everything, I think that is just going to lead to an absolute state of chaos right now in the health care system that may take a generation to recover from if we go back to square one again.

Thank you, Mr. Chairman.

Chairman HERGER. Mr. Pascrell is recognized.

Mr. PASCRELL. Thank you, Mr. Chairman. Thank you to the panelists.

I have heard, and I said many times health care reform is entitlement reform. Folks on the other side don't want to hear that. We haven't touched entitlement reform in the health care bill. I think that is utter nonsense. One-third of the health care bill is devoted to Medicare and Medicaid. It is very specific about the recommendations, and those are recommendations that we should be considering if we weren't trying to suffocate this legislation before it breathes fully in the next 2 years.

Not only are we going to reduce costs for Medicare, but also the Health Care Act reduced costs for beneficiaries, unless you don't agree with the CBO numbers. The majority's attempt to repeal reform and turn Medicare into, let's not use a voucher program, let's not use that word, I call it the more-out-of-your-own-pocket-folks program. I think that will hurt beneficiaries. And there is no doubt about it, this is going to mean more money out-of-pocket. No one has denied that. No one.

So according to the CBO office, the Republican budget will dramatically cut spending in Medicare for new beneficiaries by more than $2,200 per person per year. That is what the CBO says. And we conveniently use the CBO when they support our position, and then we tell them that they don't know what they are talking about when it doesn't support our position. And starting in 2030, by

$8,000, by 2050. If you want to talks about the future, let's talk about the future.

We don't have to scrap the current system. In fact, as we are sitting here today talking about strengthening Medicare, the health care reform bill is already hard at work actually testing new payment and delivery systems that will lead innovation not only for Medicare, but for the entire health care system. And let's talk about that health care system.

You are talking about competition. Let's increase competition in terms of Medicare. We don't have competition in the health care system. Many States have only two or three companies who write health insurance. Why don't we do something about that? If we want to foster competition, let's foster competition. We don't merely mean it. This is—it is empty. These are words that we use back and forth. This is one-upmanship. That is all we are after.

The basics of health care will be changed by the Health Care Act for the better of Americans. It will not be a socialistic system, thank God we graduated from that, since more insurance companies will be involved in order for us to gain favor with the people that we are dealing with.

You know, we are heading back to 1964. I am convinced that that is the direction we want to go in, when senior poverty was at the greatest since the Great Depression. That is where we want to go. Why don't we just say that? We are using a lot of pretty words.

Yes, you may shake your head, Ms. Rivlin, but I am telling you, we are marking time in place while many seniors are being stopped at the door because they are under Medicare. That is what we should be addressing. That is what we should be saying, enough of this. The health care system is not working. The health care system has been totally taken over by the health insurance companies of this country. You know it and I know it. We don't have competition.

In New Jersey, what would do we have, three or four companies that write health insurance? This is competition? What is this competition? You say, so we will narrow it. Maybe next year we will have three companies. Maybe Co. C will take over Co. D. In how many States do we have only three or four or less companies writing health insurance, and you want to put our seniors into that situation? That is not competition. That is a joke. You know it and I know it.

By the way, Mr. Aaron, I want to congratulate you on the work you have done. I know since I have been here for 16 years, you have been at the forefront of talking about these issues. These are critical issues for all of us. I know that it is not very popular to try to hold down out-of-pocket expenses. That is not a popular position, Mr. Aaron. But I don't care whether it is or isn't. You have done the right thing. I admire what you are doing.

We have enough here to work with within the legislation to change Medicare, but let's not throw away everything because we want to get to a few who will profit only. Thank you, Mr. Chairman.

Chairman HERGER. The gentleman's time has expired.

Dr. Boustany is recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman. I thank you for holding this hearing.

I think this has been a nice reprieve where we actually get to talk about policy, and I want to thank all the panelists here today for the serious work you have done over many, many years to advance the debate and to advance real solutions to solving health care.

Senator Breaux, let me publicly thank you for your many, many years of service to our State of Louisiana and our country and to your continued willingness to do this and to serve in a public capacity to advance the debate in health care.

Mr. Aaron, you raised the point about competition and the fact that it has not lowered costs. I would submit that we are really stuck right now between a price-controlled system and vastly imperfect competition. We don't really have the kind of competition that is necessary, both in the health care financing arena as well as in the delivery system aspect of this. And I think if we could get to more perfect competition there, we would see the advantages of lowering costs and enhancing quality. And that is coming from somebody who has had many years practicing in the health care system as a physician.

I have some really deep concerns about the tilt toward price controls in this, which I think it is pretty indisputable that that is what we are operating under right now. And the problem is we already have a serious shortage of physicians and nurses in this country, and if we continue on this path where we have seen—we are facing the cuts in sequestration, we have seen cuts year after year to providers, what is this really going to mean for access? Because coverage does not equate to access to good high quality care.

I know, Senator Breaux, you and I, actually even before I got to Congress back in the 1990s had serious concerns about trends we are seeing in the Medicare program whereby, for instance, as a heart surgeon, I would see a patient in the emergency room and do an emergency coronary bypass operation, and then in the aftermath of all that, we couldn't find a primary care physician to take care of the patient's basic health care needs. I would have to get on the phone and start begging physicians in my community that I knew well and worked with to take on a new patient. And the whole issue was the cost. The cost of care and the cost to these physician practices is not being met by reimbursement. So if we can get to a system that brings us back to a real competition, I think it makes a difference.

I want to compliment Chairman Ryan. I know he walked out. But he has actually taken a lot of the work that Dr. Rivlin and Senator Breaux, Mr. Antos, you have worked on, and Mr. Aaron, and put it into a body of work along with Senator Wyden to try to get us to that. And I don't know of any other alternative.

So, would anybody comment? Is there another alternative out there other than the premium support model?

Mr. AARON. I think the key to solving the problems that you have described, and quite eloquently, I believe, regarding the fragmentation of care comes in some of the innovations that are in the Affordable Care Act, in particular, two that I would focus on.

One is the creation of accountable care organizations, which are groups of providers who would be paid to assure the health of people who enroll with them, much as health maintenance organizations do; and the second would be bundled payments, so that in the event of a coronary artery bypass graft surgery case, a payment would be made not just for the act of surgery, but for the follow-up care as well, so that you, together with a primary care physician and perhaps a nurse practitioner who would regularly contact the patient to make sure that he or she was taking recommended medications, would all work together. That is the key.

Mr. BOUSTANY. Mr. Aaron, one of the fundamental problems not addressed in the Affordable Care Act is the—in the context of accountable care organizations is we still have Federal barriers in place that prohibit physicians to integrate care with hospitals, and that has not been addressed adequately. We need statutory relief in that area if we are going to see those kinds of innovations.

Mr. AARON. I agree with you completely, and it is an illustration of how the law may need to be amended.

Mr. BOUSTANY. Senator Breaux.

Mr. BREAUX. In alternatives, and I think that Congressman Kind had pointed this out, Ron talked about the demonstration programs that are in the Accountable Care Act. I remember when I was in Congress when I wanted to stop something from happening, I used to offer an amendment to do a study, or maybe to do a demonstration program, hoping it never got completed.

But I think the things that are in the Accountable Care Act, the demonstration programs, are very important, but you can be for both going to a premium support system and a demonstration project in the Accountable Care Act. If the demonstration programs work, it will improve the fee-for-service delivery system, and then if you have premium support, they will be better competitors. And that is what we are trying to bring about.

I think the demonstration programs are helpful, they are important, but they are not an either/or situation. You can move to a premium support system and support the demonstration projects and hope that they work very well.

Mr. BOUSTANY. Dr. Rivlin, do you want to comment?

Ms. RIVLIN. Yes, I fully support what Senator Breaux just said. It is a mistake to think of these as alternatives. At least our plan envisions that the Affordable Care Act continues, that the demonstrations and the various institutions that were set up to improve the delivery system go ahead, and we hope that works. We are only saying that there ought to be another way to get these innovations into use, and that would be competition.

Mr. BOUSTANY. Thank you. Mr. Antos.

Mr. ANTOS. I agree with that. But it would also be a mistake to believe that these things are going to materialize overnight. As someone said, the devil is in the details, and accountable care organizations are devilish.

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

Chairman HERGER. I want to thank our witnesses for your testimony today. This has been an extremely interesting discussion, one that highlights the need for Congress to act soon in order to place Medicare on sound financial footing. Premium support pro-

posals like those we heard about today hold promise to improve how care is delivered, better protect beneficiaries against Medicare's cost sharing requirements, and utilize competition to control costs for the program as a whole.

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

With that, this Subcommittee is adjourned.

[Submissions for the Record follow:]

April 27, 2012

The Honorable Dave Camp
Chairman
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Wally Herger
Chair, Health Subcommittee
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Pete Stark
Ranking Member, Health
Subcommittee
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Representatives Camp, Levin, Herger, and Stark:

I am writing to you on behalf of AARP's 38 million members and the millions of older Americans and their families who depend upon the Medicare program. Our statement today will focus on comments generally to the creation of a "premium support" system for the Medicare program. We appreciate that the House Ways and Means Committee is holding a hearing focused on the long-term future of Medicare. AARP believes it is critical that we strengthen Medicare to ensure both the health and economic security of current seniors and future generations.

AARP is concerned that rather than recognizing that health care is an unavoidable necessity which must be made more affordable for all Americans, a premium support system may simply result in a shift of high and growing health care costs onto Medicare beneficiaries, as well as a shift of even higher costs of increased uninsured care onto everyone else. The typical Medicare beneficiary today, living on an income of roughly $20,000, already struggles to pay for their ever-rising health and prescription drug costs -- and nearly 20 percent of their income currently goes to health care costs. By creating a "premium support" system for future Medicare beneficiaries, any such proposal risks simply increasing costs for beneficiaries while removing Medicare's promise of secure health coverage -- a guarantee that future seniors have contributed to through a lifetime of hard work.

Proponents of a premium support system for Medicare believe that such a system could, depending on how the government contribution to premiums was determined, reduce future federal Medicare spending. Previous proposals assumed significant savings would come from competition among private plans in Medicare. However, many critics have questioned those savings, and point out that much of the savings are achieved not by lowering health costs, but simply by shifting costs onto beneficiaries. The recent experience with Medicare Advantage, where payments to private plans have generally been higher than costs for the traditional fee-for-service (FFS) population, casts some doubt on the promise of savings through competition.

A premium support system with an inadequate government contribution would greatly increase the costs of Medicare for beneficiaries and would increase the risks beneficiaries would face under such a system. Much of the federal savings from premium support would come from increased premiums paid by beneficiaries (i.e. shifting costs from the government to beneficiaries) rather than from cost savings within the healthcare system. Especially vulnerable are those beneficiaries who are unable to afford higher premiums, including those remaining in the traditional FFS program (assuming it remained as an option), either because it was the only option available in their geographic area or because they felt it the best option for them. This would be particularly true if the FFS program included a larger proportion of the oldest and sickest beneficiaries, which could further raise costs and premiums compared with private plans. A premium support system – unlike private plan options that currently exist in Medicare -- would under this likely scenario "price out" traditional Medicare as a viable option, thus rendering the choice of traditional Medicare as a false promise.

Any Medicare reform proposal should ensure adequate affordable coverage -- especially for lower income beneficiaries -- and protect beneficiaries by maintaining a guaranteed benefits package and insuring that all plans meet quality and efficiency standards.

Various premium support proposals up to this point have failed to recognize that higher Medicare spending is driven to a large extent by high costs throughout the health care system generally. Medicare is just one part of our nation's health system, which includes public, individual, and employer-based health insurance. If we're serious about lowering health care costs, we cannot simply focus on Medicare and Medicaid for savings. Rather, we must improve the delivery of health care generally, including increasing preventive services, better

coordination of care, lowering the cost of prescription drugs, and the reduction of waste and fraud throughout the entire health care system.

Over 47 million older and disabled Americans depend on Medicare today. Giving seniors the peace of mind that they can see their doctor and afford their health care isn't a Republican or Democratic issue.

Older Americans agree it's time to work together to find solutions that will ensure that Medicare will continue to be there for them and their families. AARP is committed to working with both sides of the aisle to ensure Congress reaches a financially responsible solution that will ensure seniors have access to the doctors and services they depend on through the Medicare program. If you have any further questions, please feel free to call me or have your staff contact Ariel A. Gonzalez of our Government Affairs staff at 202-434-3770.

Sincerely,

Joyce A. Rogers

Joyce A. Rogers
Senior Vice President
Government Affairs

TESTIMONY OF KELLY ROSS
DEPUTY POLICY DIRECTOR, AFL-CIO
BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS
HEARING ON MEDICARE PREMIUM SUPPORT PROPOSALS
APRIL 27, 2012

Unless health care costs are brought under control, they are projected to bankrupt individuals, families, businesses, state governments, and the federal government by the latter half of the 21st century. The fact that Medicare has proven to be more cost effective than private health insurance plans over the past four decades suggests that the best way to contain future cost growth is to improve and expand Medicare by building on the payment and delivery reforms of the Affordable Care Act (ACA). By contrast, proposals to replace guaranteed Medicare benefits with a flat payment of premium support—also known as a voucher—would increase overall health care costs, shift costs to seniors and increase their out-of-pocket spending, create a two-tier health care system, make Medicare's risk pool more expensive to cover, and ultimately leave Medicare to "wither on the vine." The claim that these premium support proposals would reduce overall health care costs is based on ideology rather than experience or facts.

Medicare has lower costs than private health insurance plans for three reasons. First, Medicare has lower administrative costs—about 2 percent of total spending compared to 11 percent for Medicare Advantage plans.[i] Second, Medicare has enormous buying power that allows it to resist unreasonable increases in provider prices, whereas private insurance companies often lack the inclination or ability to resist rate increases in concentrated provider markets. Third, Medicare has the bargaining power necessary to prevail upon private providers to implement payment and delivery reforms that promise to bring costs under control.

In addition, Medicare has experienced *lower cost growth over time* than private insurance plans. Between 1970 and 2009, Medicare spending per enrollee grew one percentage point less each year than comparable private health care premiums—or one third less over four decades.[ii] In addition, between 2010 and 2019, Medicare spending per capita is projected to grow nearly two percentage points slower than private health insurance.[iii]

This is why proposals to replace guaranteed Medicare benefits with premium support vouchers would increase overall costs in the U.S. health care system. The Congressional Budget Office (CBO) has found that the 2011 Ryan premium support proposal would increase overall health care costs for the average 65-year-old beneficiary by 40 percent—from $14,750 to $20,500—in its first year of implementation.[iv] Over 75 years, the 2011 Ryan plan would increase the cost of providing Medicare equivalent policies by at least $20 trillion.[v]

To the extent that premium support proposals would reduce some portion of the federal government's health care costs, they would do so by shifting a much higher amount of costs to seniors. Because the value of a voucher would almost certainly fail to keep up with health care cost growth, beneficiaries would have to pay more out of pocket each year—either to buy more generous private plans or to stay in traditional Medicare—or they would have to settle for less expensive plans that provide fewer benefits or require more cost sharing. According to CBO, Rep. Ryan's 2011 premium support proposal would increase out-of-pocket health care spending per beneficiary by $6,000 in its first year of implementation—from $6,150 to $12,500.[vi] Moreover, the amount of the vouchers could be easily dialed down to shift even more costs to seniors.

Premium support proposals threaten to create a two-tier health care system. In the upper tier, the wealthiest seniors would supplement their vouchers with their own resources to access the most advanced medical care. In the lower tier, seniors with more modest resources would only be able to access care covered by their increasingly inadequate voucher.

Maintaining traditional Medicare as an alternative to private insurance plans would not remedy these defects. We know from experience that private insurance companies do not compete with traditional Medicare based on efficiency, but rather by "cherry picking" the healthiest and least expensive beneficiaries. This has been the experience of Medicare Advantage, whose private plans have a history of trying to attract healthy seniors and discouraging less healthy enrollees and whose costs per beneficiary were nevertheless 9 percent higher than traditional Medicare in 2010. This was also the experience of the Medicare + Choice program in the 1990s.

Because of this tendency of private plans to cherry pick the healthiest and least expensive beneficiaries, premium support proposals would lead to the gradual demise of Medicare as we know it. The pool of beneficiaries enrolled in traditional Medicare would be sicker and more expensive to cover. Higher costs for a dwindling pool of beneficiaries would lead to higher premiums, shrinking the risk pool further and driving up premiums further. This is known as a "death spiral," or as House Speaker Newt Gingrich called it in the 1990s, "withering on the vine." Although "risk adjustment" is designed to address this problem, experience has also shown that risk adjustment is flawed and that ultimately private plans are overcompensated for recruiting healthy beneficiaries. The important thing to understand is that Medicare would be disadvantaged not because it is less cost-effective than private insurance plans, but because it pools risk without regard to health status and does not cherry pick the healthiest and least expensive beneficiaries.

In the end, premium support proposals would not only fail to contain overall costs in the U.S. health care system, but they would cripple Medicare's superior ability to contain costs. With a dwindling number of beneficiaries, Medicare's administrative costs would increase as a percentage of spending. Medicare would lose the bargaining power needed to resist unreasonable provider price increases. And Medicare would lose the clout needed to drive payment and delivery reforms by private providers.

In short, premium support proposals would be a giant step in the wrong direction. The real problem is not Medicare spending growth per se, but overall cost growth in our health care system, which also drives up costs for Medicare. Premium support proposals would make this problem worse by driving up overall costs. Instead of crippling the ability of Medicare to contain health care cost growth, we should improve and expand Medicare and take advantage of its market power to extend payment and delivery reforms throughout the entire U.S. health care system.

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[i] Kaiser Family Foundation, *Medicare Spending and Financing* (2011), p. 5.
[ii] Paul Van de Water, "Converting Medicare to Premium Support Would Likely Lead to Two-Tier Health Care System," Center on Budget and Policy Priorities (September 26, 2011), p. 1.
[iii] Kaiser Family Foundation, "Medicare at a Glance" (November 2011).
[iv] Congressional Budget Office, "Long Term Analysis of a Budget Proposal by Chairman Ryan" (April 5, 2011); Robert Greenstein, "CBO Report: Ryan Plan Specified Spending Path That Would Nearly End Most of Government Other Than Social Security, Health Care, and Defense by 2050," Center for Budget and Policy Priorities (April 7, 2011), p. 3.
[v] Center for Economic and Policy Research, "Representative Ryan's $30 Trillion Medicare Waste Tax" (April 2011), p. 1, fn. 3.
[vi] Congressional Budget Office, "Long Term Analysis of a Budget Proposal by Chairman Ryan" (April 5, 2011); Robert Greenstein, "CBO Report: Ryan Plan Specified Spending Path That Would Nearly End Most of Government Other Than Social Security, Health Care, and Defense by 2050," Center for Budget and Policy Priorities (April 7, 2011), p. 3.

Statement for the Record
by the

American Federation of State, County and Municipal Employees (AFSCME)

for the Hearing
on

Medicare Premium Support Proposals

Before the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

April 27, 2012

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by the
American Federation of State, County and Municipal Employees (AFSCME)

For the Hearing on
Medicare Premium Support Proposals

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
April 27, 2012

This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME), for the hearing held April 27, 2012 on Medicare Premium Support Proposals.

AFSCME is proud of labor's historic role in the creation Medicare. It is an indispensable federal social insurance program. Medicare provides what commercial health insurance companies did not, would not, and could not; affordable, adequate health coverage for America's elderly population regardless of income or health status. Before the enactment of Medicare, only half the population age 65 and older had health insurance and, those who did have coverage, paid close to triple what younger people paid for premiums and other out-of-pocket costs.

Before we evaluate premium support proposals, it is important to briefly review Medicare's core purposes and how Medicare has successfully pooled our nation's resources to equitably meet an ongoing need for each generation.

Medicare Is Not and Should Not Be Like Commercial Insurance

Medicare and private plans may seem as being similar in that both allow individuals to go to a doctor and get medical treatment. The foundation and purpose of Medicare is profoundly unlike commercial health plans. As a social insurance plan, Medicare's purpose is to absorb and spread risk, serving individuals who may have costly and complex medical needs as well as the relatively healthy. Medicare unites the resources of the entire nation to shield one generation after another of older Americans and individuals with disabilities from financial ruin in the event of illness, injury or expensive chronic conditions. All American workers contribute to fund the program and reap the benefits of the program once they are eligible. No one is shut out because of health status or income. Medicare by design pays for all necessary medical care for beneficiaries. Medicare will pay claims without discriminating against an individual because of where they live, their history, their diagnoses or preferences. President Johnson's Medicare signing statement addressed the core American values at the heart of Medicare's financial and benefit design — individual dignity, fairness, and safeguarding the common good:

> "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young

families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

Private health insurance companies have a very different purpose and function. Their business interest is to avoid selecting individuals with medical needs in order to maximize profits. In short, insurance companies seek to avoid risk, not pool it.

Medicare Successfully Pools Risk to Deliver Guaranteed Benefits

The Budget for FY 2013 passed by the House of Representatives along party lines, calls for a radical restructuring of Medicare and a repeal of the Affordable Care Act (ACA). The justification for such changes is to reduce the deficit and to rein in the so-called "out-of-control" spending in Medicare and to save the future of Medicare. Analysis of data actually shows these justifications to be highly questionable.

Historically, Medicare per capita spending has grown a bit slower than the private sector's. Medicare's growth rate is remarkably low when it comes to health care costs per person.[1] Over the next decade, Medicare's per beneficiary rate of growth is projected to be low, *in large part due to changes in the Affordable Care Act (ACA).*

The ACA promotes cost-efficient delivery of quality care under Medicare. The law taps into Medicare's purchasing power to prompt providers, who are increasingly concentrated and can effectively drive up payments regardless of quality, to do more to control their costs.[2] It is important to highlight that none of the payment reforms affect Medicare's guaranteed benefit packages. In fact, the law spells out loud and clear that the guaranteed benefits in Medicare Part A and Part B will not be reduced or eliminated as a result of changes to the Medicare program.

The ACA protects taxpayer and Medicare dollars against fraud in Medicare. In 2011, Medicare used the new ACA enforcement tools to recover nearly $4.1 billion from individuals and companies who attempted to defraud seniors and taxpayers. In most cases, they charged Medicare for services never received by beneficiaries, or deliberately overcharged for services rendered.

The fiscal improvements in the ACA help Medicare to hold down premium increases for beneficiaries who are older and sicker than the non-Medicare population. The Congressional Budget Office (CBO) finds that Medicare premiums, currently estimated to be 11 percent lower than private insurance premiums for the same benefit package, will be about 30 percent lower by the end of the next decade.

Because the funding structure of Medicare – through payroll contributions, revenues and beneficiary cost-sharing – fluctuates with the economy, the surefire way to fortify the solvency of Medicare and address the deficit is to improve the economy. Creating jobs, closing corporate

[1] http://www.urban.org/UploadedPDF/412544-Medicare-Medicaid-and-the-Deficit-Debate.pdf

[2] *Ibid.*

tax loopholes and requiring the wealthiest Americans to pay their fair share will help Medicare and its beneficiaries.

Redesigning Medicare: Premium Supports

The need for Medicare to remain a refuge against financial ruin caused by the caprice of illness and disability rings as true today as it did nearly half a century ago when Medicare was created. Any proposal to redesign or structurally change Medicare should be able to affirmatively meet at least three criteria which are at the heart and soul of Medicare.

1) Does the proposal effectively spread risk and deliver guaranteed benefits of medically necessary care, regardless of an individual's medical condition?
2) Does the proposal effectively continue Medicare's core function of pooling resources to finance health coverage for seniors and individuals with disabilities?
3) Does the proposal effectively continue Medicare's core purpose of protecting beneficiaries and their families from financial ruin due to illness, disease or injury?

The House-passed budget which restructures Medicare into premium supports, cuts benefits, raises the age of eligibility and repeals the ACA, fails on all three criteria.

The budget plan replaces Medicare's guarantee of health coverage and set premiums. Instead, future retirees would be given a flat payment, or voucher, that beneficiaries would use to purchase either private health insurance or traditional Medicare. The voucher is designed to lose value over time so that more and more of the cost of coverage (premiums and cost sharing) would be shifted to beneficiaries. Because the median income of Medicare households is about $25,000 a year, and most spend three times as much of their budgets on out-of-pocket health expenses compared to non-Medicare households, many retirees would find that coverage is unaffordable at higher costs.

According to the CBO, the premium support or voucher proposal will increase costs for Medicare beneficiaries by more than $2,200 per beneficiary starting in 2030 and increasing to $8,000 in 2050.

Offering both private plans and traditional Medicare uses the promise of choice to disguise the diminishment of Medicare's function to deliver guaranteed benefits and pool resources and spread risk. The private plans, like the private Medicare Advantage plans, will still cherry-pick healthier and less costly enrollees and leave Medicare with a less healthy pool of beneficiaries. Over time, traditional Medicare will become less affordable, causing costs to rise for sicker and older beneficiaries.

There is no guarantee that the premium support or voucher would cover the cost of Medicare at the start or over time. Currently, Medicare premiums are the same, regardless of where a beneficiary resides in our nation. There is no guarantee that the premiums will be adequate to cover a private Medicare plan regardless of location.

The private plans would not be required to provide the guaranteed benefits under Medicare. The private plans would only be required to provide the actuarial equivalent of the benefits under traditional Medicare. Again, the history of beneficiary abuse and exploitation by

Medicare Advantage private plans illustrate the dangers for health and financial security of the sickest and oldest beneficiaries.

Conclusion

Medicare is an amazing success story – providing health and financial security to millions of Americans, even during the worst economic crisis since the Great Depression. AFSCME opposes the House-passed budget's restructuring of Medicare because it would expose older Americans and their families to financial ruin caused by the caprice of illness and disability. It would allow sick and older seniors and individuals with disabilities to be denied the promise of modern medicine because of income and health status. In short, we oppose the premium support or voucher proposal because it ends Medicare, as we know it.

STATEMENT FOR THE RECORD

SUBMITTED TO THE HOUSE WAYS & MEANS HEALTH SUBCOMMITTEE

ON

PREMIUM SUPPORT AND ITS IMPACT ON MEDICARE BENEFICIARIES

APRIL 27, 2012

ALLIANCE FOR RETIRED AMERICANS

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The Alliance for Retired Americans submits this statement to the House Ways & Means Subcommittee on Health Care to express our strong opposition to the premium support provision included in this year's House Budget Resolution, H. Con. Res. 112. Premium support would end Medicare as we know it for Medicare beneficiaries, removing the guaranteed benefits that have provided health security for our nation's retirees and the disabled since 1965.

Founded in 2001, the Alliance is a grassroots organization representing more than 4 million retirees and seniors nationwide. Headquartered in Washington, D.C., the Alliance and its 32 state chapters works to advance public policy that strengthens the health and economic security of older Americans by teaching seniors how to make a difference through activism.

Premium support, as proposed under the House budget, will be devastating for many seniors. The plan ends the guaranteed benefits under Medicare, which assures beneficiaries that any and all services that are medically-necessary will be covered. Under premium support, beginning in 2023, Medicare beneficiaries would receive a fixed stipend to be used to purchase insurance through a Medicare exchange. Beneficiaries could choose between private plans or traditional Medicare. The problem with this proposal is that the capped payment would not keep up with medical inflation. Instead, the fixed stipend would be indexed to the gross domestic product (GDP) plus one percent – a calculation that does not adequately account for rising medical costs. Over time, as medical costs continue to rise, the capped stipend would be insufficient to cover the premiums, requiring seniors and the disabled to spend more and more money out-of-pocket to get the same care they currently receive under traditional Medicare. While higher income beneficiaries may be able to afford the higher premiums or increased out-of-pocket costs, most Medicare beneficiaries would not. This will produce a two-tiered system of care, with the wealthy having access to all the latest technology and treatment, while the rest of the population goes without. Contrary to the image that seniors are well off, half of the people on Medicare have incomes below $22,000 a year. To make matter worse, Medicare beneficiaries already spend 15% of their income on heath care costs, which is three times more than the rest of the population. The added out-of-pocket costs under the Ryan Republican budget will force many Medicare beneficiaries to be underinsured and, in many instances, forgo needed medical treatment.

Furthermore, premium support may very well be the demise of the Medicare program. Proponents argue that premium support allows Medicare beneficiaries to stay on traditional Medicare. While this may be true initially, it is uncertain whether that will hold true in the future. Based on the experience of Medicare Advantage plans, one can expect that private insurers under premium support will likely cherry pick the healthiest patients leaving Medicare with sicker and more chronically ill individuals. This will

undoubtedly increase costs for those under traditional Medicare. Medicare has historically been more efficient than private insurance, in part due to its enormous risk pool. However, should Medicare become saddled with sicker patients, its premiums will rise, causing even more of the healthy beneficiaries to abandon the program. The continuous rise in premiums and subsequent drop in enrollment could undermine the entire program as increased costs make the program unaffordable and unsustainable.

Finally, premium support does nothing to address the true drivers of rising health care costs. Instead of implementing reforms that will bend the cost curve, premium support, as adopted in the Ryan Republican budget, simply shifts the costs on to beneficiaries. If Congress is serious about reducing health costs, it should allow the new cost-savings initiatives in the Affordable Care Act to be implemented. These pilot programs are well thought out and have been successful in reducing costs while improving the overall health of the population. Furthermore, the new initiatives do not reduce health expenditures by transferring the costs on to beneficiaries.

In addition to premium support, there are various other ideas that have been proposed to help reduce the cost of health care, including raising the Medicare eligibility age, instituting a single Medicare deductible and charging a surcharge on Medigap policies. Like premium support, these policies are short-sighted and not in the best interest of Medicare beneficiaries. They seek to reduce health costs by shifting it to those who can least afford it. As Congress deliberates on ways to reduce health costs, members should keep the need of seniors and the disabled first and foremost on their minds and not make radical, harmful changes such as those in the Ryan Republican budget.

Comments for the Record
House Committee on Ways and Means
Subcommittee on Health
Hearing on Medicare Premium Support Proposals

Friday, April 27, 2012, 9:00 AM

by Michael G. Bindner
The Center for Fiscal Equity

Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit my comments on this topic.

The whole purpose of social insurance is to prevent the imposition of unearned costs and payment of unearned benefits by not only the beneficiaries, but also their families. Cuts which cause patients to pick up the slack favor richer patients, richer children and grand children, patients with larger families and families whose parents and grandparents are already deceased, given that the alternative is higher taxes on each working member. Such cuts would be an undue burden on poorer retirees without savings, poor families, small families with fewer children or with surviving parents, grandparents and (to add insult to injury) in-laws.

The key issue for the future of health care finance is the impact of pre-existing condition reforms on the market for health insurance. Mandates under the Affordable Care Act (ACA) may be inadequate to keep people from dropping insurance - and will certainly not work if the mandate is rejected altogether for constitutional reasons.

If people start dropping insurance until they get sick – which is rational given the weakness of mandates – then private health insurance will require a bailout into an effective single payer system. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions while repealing mandates and pre-existing condition reforms.

In the event that Congress does nothing and private sector health insurance is lost, the prospects for premium support to replace the current Medicare program is lost as well. Premium support also will not work if the ACA is repealed, since without the ACA, pre-existing condition protections and insurance exchanges eliminate the guarantee to seniors necessary for reform to succeed. Meanwhile, under a public option without pre-existing condition reforms, because seniors would be in the group of those who could not normally get insurance in the private market, the premium support solution would ultimately do nothing to fix Medicare's funding problem.

The alternative of single-payer catastrophic insurance with health savings accounts would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

Bruce Bartlett wrote in the New York Times Economix Blog on May 17, 2011 on the nature of the Medicare financial problem and how to fix it. The information he imparted is invaluable, however I disagree with his solution, which is to stop doing the Doc Fix. He relates that the ACA expansion of funding brought the Hospital Insurance Trust Fund (Part A) into balance, with parts B (doctor visits) and D (Drug coverage) responsible for most of the unsustainable cost growth, as patient premiums are set to 25% of program costs and with drug coverage premiums covering even less.

The Center believes that stopping doctor bills from going up on the demand side will not work. We know that because it did not work for Medicaid - since restricting payments have stopped most doctors from taking Medicaid). This finding has a great deal of impact on what is possible in preventing the doctor fix.

The problem with Medicare Part B is that increases cannot keep up with costs, like they do in the private market, because doing so violates the commitment to not cut Social Security benefit checks. The cost of living adjustment must be high enough to cover the premium increase each year - although for many that is all it does. Further cuts bring up the specter of seniors eating cat foot to make ends meet, hence the reason that the Fiscal Commission was called the Cat Food Commission by progressives.

Premium support and not patching doctor fees are attempts to make doctors restrict their costs - both to seniors and overall. Prices naturally rise more quickly than inflation because these services are subsidized, so any co-pay must be increased to slow demand from users in exactly the same way the market would without subsidies or insurance. The desire to make doctors pay more is a recognition that the main impact of both insurance and subsidies (and subsidies for insurance) is higher income for doctors and a larger medical care sector than would otherwise occur in a free market.

Our hybrid system is the most expensive option - either going to much less comprehensive insurance for everyone or an entirely governmental system would be cheaper, but is politically untenable (at least until private insurance collapses or is eventually supplanted by an ever expanding public option).

Going after doctors still won't work, however, as the Medicaid experience clearly shows. Premium support is a way to have insurance companies go after doctors instead, but that will likely yield the same result.

Making patients more conscious of their care might do the trick, both with more realistic premiums for Part B and Part D, with both rising to absorb half the cost - although premiums could be lowered by increasing co-pays and providing seniors with Flexible Spending and/or health savings accounts. The problem is that this is untenable when dealing with a population with largely fixed incomes. That problem, however, is not unsolvable.

The obvious solution, which no one has yet suggested, is to change how COLAs are calculated, moving from the wage index to an index based on what seniors actually buy - especially health care. If premiums were increased quickly, COLA changes would have to be as rapid.

Such a proposal would hasten the date that the Old Age and Survivors Insurance fund needs rescue. It also impacts lower income seniors to a greater extent than higher income seniors, since they have less left over after any mandatory co-pay. Either bend points would have to be reset or the entire complicated system of bend points would have to be replaced a new method of crediting contributions, where employer contributions are credited equally rather than as a match to the employee contribution - thus moving redistribution from the benefits side to the revenue side.

An average employer contribution would provide even more incentive for increasing the amount of income subject to benefits, at least for the employer contribution. Of course, if you do the latter, we might as well simply use a Net Business Receipts Tax or a VAT to replace the employer contribution (which captures all income with the latter burdening imports as well)

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding).

We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so we will confine our remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns. The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

The NBRT would replace disability insurance, hospital insurance, the employer contribution to old age and survivors insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets. Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

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Subcommittee on Health

Hearing on Medicare Premium Support Proposals

Friday, April 27, 2012, 9:00 AM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

Consumers Union

POLICY & ACTION FROM CONSUMER REPORTS

Written Testimony of

Consumers Union

on

Medicare Premium Support Proposals

Submitted to
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
April 27, 2012

Introduction

Consumers Union, the policy and advocacy arm of Consumer Reports[1], appreciates this opportunity to provide written testimony on Medicare premium support proposals currently being considered as an alternative to traditional Medicare.

Medicare provides essential health coverage for almost 50 million American seniors and persons with disabilities. Medicare faces financial challenges, primarily as a result of increasing enrollment due to retiring baby boomers. Importantly, however, Medicare per enrollee spending has been slightly *below* that of private insurance.[2]

Premium support proposals seek to transform Medicare from a defined benefit program, in which beneficiaries are guaranteed coverage for a fixed set of benefits, to a defined contribution or "premium support" program, in which beneficiaries are guaranteed a fixed federal payment (or voucher) to help cover their health care expenses.

Consumers Union believes that this approach to addressing the real financial challenges to Medicare will not reduce overall health care costs, but will put millions of senior and disabled Americans at greater risk of higher costs, less coverage, or both.

Unacceptable Transfer of Risk to Beneficiaries

Under these proposals, a large amount of risk is transferred to Medicare beneficiaries.

Beneficiaries are at risk for the escalation of medical costs above Gross Domestic Product (GDP) +.5 percent. There are no guarantees that the proposal will hold down per capita cost growth. Instead, we argue below that cost control is unlikely, and thus is likely to increase costs for Medicare beneficiaries, most of whom. live on modest, fixed incomes and are not in a position to pay much more for their health care.

In addition to this financial risk, in a world of multiple and varying plan designs beneficiaries are at risk for being able to identify the plan that provides the best coverage. The "premium support" proposals will require health plans to offer coverage that is "actuarially equivalent" to today's Medicare Fee-for-Service (FFS) plan. This means that the Medicare benefit design would no longer be standardized, requiring beneficiaries to

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[1] Consumer Reports is the world's largest independent product-testing organization. Using its more than 50 labs, auto test center, and survey research center, the nonprofit rates thousands of products and services annually. Founded in 1936, Consumer Reports has over 8 million subscribers to its magazine, website, and other publications. Its advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and in the marketplace.
[2] John Holahan and Stacey McMorrow, "Medicare, Medicaid and the Deficit Debate: Timely Analysis of Immediate Health Policy Issues", Urban Institute, April 2012.

understand how countless complex designs would affect them. There is overwhelming evidence that consumers have difficulty understanding and comparing the cost-sharing provisions of health plans.[3] We must recognize that these products are not cans of soup that can be easily compared, especially with new and "innovative" products coming on the market. Innovation is often accompanied by additional complexity for consumers.

Some proposals promise to provide voucher recipients with 'clear and easy to understand information' on various plans. Health plans, the National Association of Insurance Commissioners (NAIC) and consumer assistors everywhere have been trying to convey understandable information on health plan features for years. Indeed, several regulations require that various health plan summaries be understandable to the average health plan enrollee. However, we have *no* evidence thus far that these are successful.[4] The reasons vary: the underlying information is complex and new methods of usefully summarizing are only just coming online.[5] In short, these proposals put seniors at risk of obtaining coverage that they do not understand and that does not cover their needs.

Harnessing Market Forces – How Realistic?

Harnessing market forces to achieve the policy goal of adequate health coverage for seniors in a financially sustainable method is a theory that needs a careful reality check.

As some of the proposals recognize, harnessing competition among private insurance plans to achieve a policy goal takes aggressive government intervention and oversight. The market cannot operate unfettered because certain outcomes, such as engaging in risk selection or discriminatory plan designs, are a natural by-product of private insurance company activity. Yet these practices undermine the policy goals of adequate, affordable coverage for all seniors.

Experience with the Medicare Advantage program shows us how hard it is to get this oversight right. Rules governing benefit design, marketing and other practices have had to be continuously fine-tuned due to private insurer predilections to attract the healthiest risks.

Policy approaches that "harness the market" require rules with respect to consumer protections, monitoring and enforcement.. We can expect that in all these activities

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[3] Ted von Glahn. "Consumer Choice of Health Plan Decision Support Rules for Health Exchanges", Pacific Business Group on Health, February 2012. Lynn Quincy. "What's Behind the Door: Consumers' Difficulties Selecting Health Plans". Consumers Union, January 2012.

[4] Colleen E. Medill, EBRI Fellow, Richard L. Wiener, Brian H. Bornstein, and E. Kiernan McGorty, "How Readable Are Summary Plan Descriptions For Health Care Plans?". EBRI Notes, October 2006. This study found that the average readability level for important information concerning eligibility, benefits, and participant rights and responsibilities in summary plan descriptions is written at a first year college reading level, despite a requirement that the materials be understandable to the average plan enrollee.

[5] The Kleimann Group and Consumers Union, "Early Consumer Testing of the Coverage Facts Label", August 2011.

insurers and other interested parties will try to affect rules at the state and federal level to ensure that more advantage falls their way, to the detriment of sicker patients.

Little Evidence That Costs Would Be Lower

Proponents argue that the premium support approach can be used to lower health care costs, compared to traditional Medicare. This must be examined critically from three perspectives.

One, it is not just federally financed costs that need to be considered but overall costs, including the consumer's out-of-pocket share. Merely shifting costs to consumers is not an acceptable policy solution. The Congressional Budget Office (CBO) projects that *total* health care spending for a typical beneficiary covered by the standardized benefit under at least one of the proposals would grow faster than such spending for the same beneficiary in traditional Medicare.[6]

Two, the ingredients for a competitive market place - one capable of driving down prices - are missing. As discussed above, consumers have tremendous difficulty distinguishing among health plans – a key requirement for a functioning marketplace. Consumers also lack the necessary price transparency, ability to evaluate alternate treatments and confidence to make market driven decisions when consuming health care services. For serious medical conditions, most consumers defer to the treatment recommended by their doctors. And as mentioned above, effective risk adjustment mechanisms and understandable health plan disclosures that are key to this type of approach need to be greatly improved.

Three, there is little evidence that costs would be lower. The CBO estimates that a private health insurance plan covering the standardized benefit would be more expensive currently than traditional Medicare.[7] This should not be surprising. The Medicare Advantage program – a market-based alternative to traditional Medicare – costs more, not less, per beneficiary.[8] Those fixed monthly payments to Advantage plans are, on average, 13 percent above Medicare FFS costs.[9]

More broadly, private plans operating in the commercial market place now have provided little evidence that they can lower costs more successfully than Medicare's current approach.

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6 Elmendorf, April 5, 2011 letter to Honorable Paul Ryan, http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf

[7] Ibid.

[8] The Medicare Advantage program shares many of the same features of the premium support program. The plans must offer a benefit that is actuarially equivalent to Medicare. They face anti-discrimination rules and receive risk adjusted payments from CMS. Costs for extra benefits are borne by beneficiaries. Despite these program features, costs are higher in the Medicare Advantage program.

[9] Brian Biles and Grace Arnold, "Medicare Advantage Payment Provisions: Health Care and Education Affordability Reconciliation act of 2010 H.R. 4872", George Washington University School of Public Health, March 2010.

Medicare's Financial Challenges Can Be Addressed

We can all agree that Medicare finances need attention. However, experts agree that there are multiple ways to address Medicare's financing gap.

For example, there is wide-spread agreement that adopting measures such as reducing the use of redundant or unnecessary tests, reducing the use of treatments that evidence shows are not effective, increasing the use of generic drugs, and increasing the effectiveness and use of preventive care can all reduce cost-growth. The Affordable Care Act introduces numerous pilots designed to alter provider incentives to reduce the use of the unnecessary services.

As we wait for the evidence from these pilot programs, numerous other proposals have been offered to achieve the savings needed, such as extending Medicaid drug rebates to Medicare dual eligibles.[10] Many experts believe that significant savings could be obtained if Medicare is allowed to negotiate drug prices. Current law bars the Centers for Medicare and Medicaid Services (CMS) from negotiating the prices for drugs. This is in stark contrast to the Veteran's Administration (VA), which negotiates directly with drug manufacturers and is not bound by the same formulary rules as Medicare Part D prescription drug plans.[11]

Greater Choice For Beneficiaries

Another argument often made for premium support proposals is that beneficiaries will benefit from greater choice. Decision-makers must critically examine and reject this oft made argument. The research literature is clear that while a few choices are good, too much choice undermines consumer decision-making.[12] As cognitive function declines, it becomes even more difficult to navigate multiple choices.

In summary, Consumers Union can not support moving Medicare in the direction of the private commercial insurance market, which is more expensive, has higher administrative costs and would put Medicare beneficiaries at much greater risk. There are numerous

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[10] Robert A. Berenson and John Holahan, "Preserving Medicare: A Practical Approach to Controlling Spending", the Urban Institute, September 2011.
[11] Frakt, AB, ,S. Pizer and R. Feldman, "Should Medicare adopt the Veterans health administration formulary?", *Health Care Financing & Economics*, May 2012.
12 Yaniv Hanoch et al., "Choice, Numeracy, and Physicians-in-Training Performance: The Case of Medicare Part D", *Health Psychology*, July 2010; Stacey Wood et al., "Numeracy and Medicare Part D: The Importance of Choice and Literacy for Numbers in Optimizing Decision Making for Medicare's Prescription Drug Program" *Psychology And Aging*, June 2011; J. Michael McWilliams et al., "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those With Impaired Decision Making", *Health Affairs*, September 2011.

other steps that could be taken to help shore up the Medicare Trust Fund while working to address the broader cost issues that affect all of the health care sector.

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Written Statement for the Record by

Families USA

For the U.S. House of Representatives

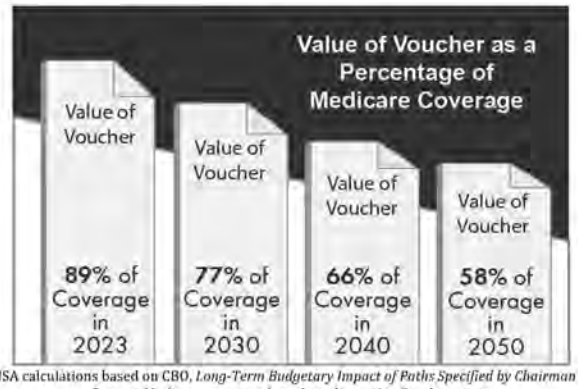
Committee on Ways and Means

Hearing on Medicare Premium Support Proposals

Friday, April 27, 2012

The House budget resolution (H. Con. Res. 112) passed on March 29, 2012 calls for replacing the current Medicare program with a voucher-based system called "premium support." Families USA is deeply troubled by the implications of such a system. If enacted, this plan would have devastating consequences for seniors and people with disabilities who rely on Medicare today and for those who will need it in the future.

Under this vision for Medicare, the program's current guarantee of coverage for everyone who qualifies will end and be replaced with a promise of a fixed amount of money (i.e., a voucher) to purchase health insurance. The plan shifts risk and costs onto individuals. If the voucher is insufficient to purchase comprehensive coverage, individuals would have to either pay for the rest of their care out of their own pockets or go without it. Medicare would face greater and greater cuts over time, with payments on behalf of beneficiaries being cut by 23 percent within seven years of the new system taking effect and a 42 percent cut after twenty-seven years.



Source: Families USA calculations based on CBO, *Long-Term Budgetary Impact of Paths Specified by Chairman Ryan*, March 2012. Current Medicare coverage based on alternative fiscal scenario

The premium support plan does not "preserve" Medicare—it ends Medicare as we know it.

- Even if something called "Medicare" still exists under this plan for the program, it will provide less protection and cost more than the program we have today.

- Calling something "Medicare" does not make it Medicare. A vehicle that's missing wheels, brakes, and doors is not a "car," no matter what a salesman calls it.

The premium support plan raises beneficiaries' out-of-pocket costs.

- The amount of the voucher will not keep up with increases in health care costs.
- Over time, the voucher will buy less and less coverage, and the beneficiaries will have to either pay more or go without care.

The premium support plan relies on costly private insurance companies.

- Private plans in Medicare have always, on average, cost more, not less, than the traditional Medicare program *to deliver the same care*.
- Private health insurance companies have higher administrative costs than Medicare and must pay for marketing, salaries, advertising, and profits.
- Private insurance companies' poor track record in controlling Medicare costs suggests that premium support will not be able to save money without passing costs onto beneficiaries.

The premium support plan puts current beneficiaries at risk, too.

- Even if the premium support proposal is phased in and traditional Medicare remains an option in the future, current beneficiaries will face higher costs.
- Healthier and wealthier beneficiaries will likely leave traditional Medicare for cheaper private plans that provide less protection because they can afford to pay additional out-of-pocket costs themselves.
- Higher-cost patients will remain in traditional Medicare, thereby pushing up Medicare premiums for everyone left in the program. Higher premiums would encourage more people to leave traditional Medicare, increasing Medicare's costs further.

The premium support plan does not address Medicare's fiscal challenges—it just shifts costs to seniors and people with disabilities.

- The key to fixing Medicare's fiscal problems is to slow the rate of health care cost growth.
- The Affordable Care Act lays the groundwork for making the health care system more efficient by encouraging doctors and other health care providers to work together to improve quality, keep people healthy, and reduce unnecessary care.
- Already, Medicare's annual costs have grown more slowly in recent years than in prior decades. We need to let these reforms take root.

The budget proposal is the latest attempt to turn Medicare into a private voucher system and comes with all the same problems as previous proposals. But the plan offers no explanation for how seniors and people with disabilities are expected to pay for the care they need as the value of their voucher declines. The roughly half of people with Medicare who have limited income would be forced to cut back on other necessities like food and shelter –or go without healthcare. If enacted, this proposal would fundamentally violate the promise that Medicare has made to current and future generations, which is to ensure access to comprehensive care at a time in their lives when they are most vulnerable.

HEALTH CARE FOR AMERICA NOW!

Strengthen Medicare. Don't End It.

Medicare provides health and financial security to 48 million older and disabled Americans, and it provides us all with the security of knowing that our relatives will be protected from unforeseeable risks in old age or disability. With private pensions evaporating and personal savings eroding in the midst of an economic crisis, Medicare is more vital than ever. "Premium support" would privatize Medicare and end Medicare as we know it, both by eliminating the Medicare guarantee and shifting huge costs to enrollees.

Medicare works, and we need to keep it strong for future generations. The Affordable Care Act (ACA) has already made several changes that make Medicare both more cost effective and better insurance for seniors.

- The ACA will save taxpayers more than $200 billion by 2016, resulting in an immediate benefit to the Trust Fund. None of these savings come from shifting costs to seniors. Most will be achieved by ending overpayments to private insurers and paying doctors for doing good work instead of just more work.[1]
- The ACA improved Medicare's long-term financial outlook. Medicare's Trust Fund is fully funded for the next 12 years, while the historical average projected lifespan of the fund is 11.3 years.[2] Efforts to repeal the ACA weaken Medicare's financial outlook.
- In 2011, seniors who reach the prescription drug coverage gap, or doughnut hole, will receive a 50 percent discount when buying Medicare Part D covered brand-name prescription drugs. Over the next 10 years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed for good in 2020.[3]
- The law provides certain preventive services, such as annual wellness visits, tobacco cessation counseling, preventive screenings, and personalized prevention plans, at no cost for seniors on Medicare.[4]
- The ACA established a new Center for Medicare & Medicaid Innovation that will begin testing new ways to buy and deliver care that improve quality while lowering costs.[5]
- The law established the Community Care Transitions Program, which helps high-risk hospitalized Medicare beneficiaries avoid unnecessary readmissions by coordinating care and connecting patients to community-based services.[6]

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[1] Center for Medicare and Medicaid Services, "The Affordable Care Act: Lowering Medicare Costs by Improving Care", 2012.
[2] Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 1970-2011.
[3] US Department of Health and Human Services, "The Healthcare Timeline" 2012
[4] US Department of Health and Human Services, "The Healthcare Timeline" 2012
[5] US Department of Health and Human Services, "The Healthcare Timeline" 2012
[6] US Department of Health and Human Services, "The Healthcare Timeline" 2012

It is misleading to say that Medicare is "bankrupt."

- After 2024, revenue still will be able to cover about 87% of Hospital Insurance costs.[7] Physician and outpatient services and the prescription drug benefit are not – and cannot – be insolvent. There is a shortfall in Hospital Insurance funding, but it is disingenuous and deceptive to scare seniors by saying that Medicare is "bankrupt."

Private insurance is hardly an appropriate model for Medicare's future. Private insurance has proved itself far less effective in controlling costs.

- Unlike private insurance, Medicare's per-capita costs are growing at the same pace as GDP.[8]
- On average, per capita costs have risen 1% less in Medicare than in private insurance each year since 1970. That means private insurance premiums have risen almost 60 percent faster than Medicare's per capita costs.[9]
- The CBO projects that privatizing Medicare would lead health care costs to be 60 percent higher for a typical 65-year old by 2035.[10]
- Private insurers concede they cannot control costs.[11] The cost of health coverage has outstripped the growth of wages, eating into family income.[12] Many employers are cutting benefits and raising co-pays or eliminating coverage altogether.[13] This is why the Affordable Care Act is so important to families.
- Over the next decade, private insurance premiums are projected to rise nearly 50 percent faster than the per capita cost of Medicare each year.[14]

Since Medicare is more efficient than private insurers, the only way a premium support system can save money for the government would be by shifting costs to older and disabled Americans.

- "Premium support" shifts costs to enrollees.[15]
- The voucher plan proposed in Budget Committee Chairman Paul Ryan's latest budget controls spending by cutting the value of the voucher.[16]

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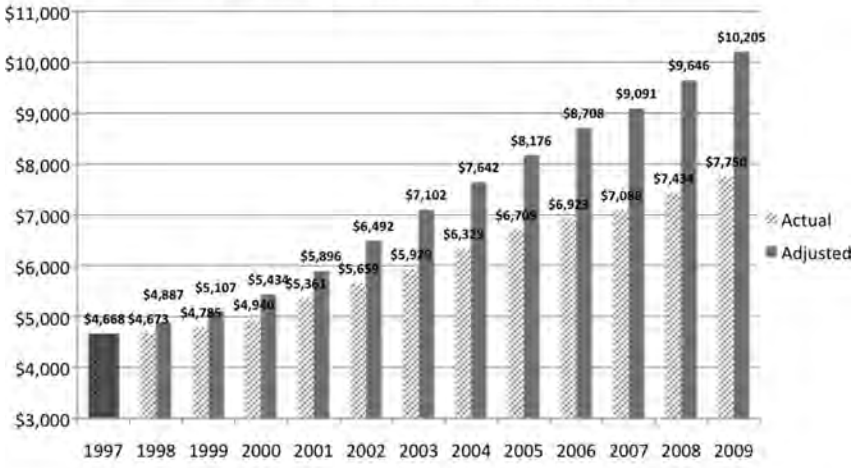
[7] Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report*, April 23, 2012.
[8] John Holahan and Stacey McMorrow. "Medicare, Medicaid, and the Deficit: Timely Analysis of Immediate Health Policy Issues." Urban Institute. April 2012.
[9] CMS, *NHE Web Tables* (Washington, DC: 2009), Table 13.
[10] CBO, *Long-Term Analysis of a Budget Proposal by Chairman Ryan* (Washington, DC: Apr. 5, 2011), 22.
[11] http://www.help.senate.gov/imo/media/doc/Ignagni3.pdf
[12] For income figures, see *Current Population Survey, Annual Social and Economic Supplements*, Sept. 2011, Table 8. For insurance costs, see Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2011 Annual Survey*, 69.
[13] Commonwealth Fund, *State-Level Trends in Employer-Sponsored Health Insurance: A State-by-State Analysis*, June 2011.
[14] For total benefits. CMS, *National Health Expenditure Projection, 2010-2020* (2011), Table 17.
[15] Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What Is the Next Step?," *Health Affairs*, 14(4): 8-30 (Winter 1995).
[16] Van de Water, Paul N. "Ryan-Wyden Premium Support Proposal Not What It May Seem." Center for Budget and Policy Priorities. Dec 21, 2011.

Annual Medicare Per-Capita Spending, 1997-2009,
Actual Spending vs. Hypothetical Spending at Private Health Insurance Growth Rates



In order to get a handle on skyrocketing health care costs, we need to develop new health care delivery systems that coordinate care for the people with the highest costs and create new payment methods that reward value, not volume. **Medicare is essential to driving needed reforms because it gives policymakers the means to encourage providers to adopt best practices. No private health insurance company has the influence that Medicare has to change these practices.**

- Medicare has a history of driving innovations later adopted throughout the health care sector. For example, Medicare's fee schedule, adopted in the 1980s to prevent providers from setting exorbitant rates, is the basis for prices throughout the system.[17]
- The Affordable Care Act gave Medicare the mandate and the resources to develop pilot programs to test the effectiveness of different system reforms, which create financial incentives for providers to improve care while controlling costs.
- Developing reliable measures of what works and what doesn't is key to long-term savings, but it's a long-term process that's just beginning.[18] Insurance companies are prevented by

[17] Uwe Reinhardt, "How Medicare Pays Physicians," New York Times, December 2010.

competitive imperatives and short-term thinking from making long-term commitments to studying the health system or to sharing findings with rivals.

Medicare covers a population that would have extreme difficulty shopping for coverage.

- Surveys show that 29% of seniors have "below basic" health literacy, meaning they lack the "capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[19]
- Nearly one-third of Medicare enrollees have some sort of a cognitive impairment.[20]

Commercial insurers' business model is built on denying coverage to the most vulnerable.

- Commercial insurers are likely to engage in a practice known as "risk-selection" or "cream skimming." Insurers design benefits in ways that do not meet the needs of the sickest individuals, steering the most vulnerable into public programs, a practice that becomes increasingly unaffordable because it covers a very risky population. This creates a two-tiered health care system: a low-cost one for the healthy, and an extremely expensive one for the sick.[21,22]
- The government can try to address adverse risk-selection by making enhanced "risk-adjustment" payments designed to shield health plans from the costs of covering the most vulnerable, but Medicare Advantage plans have proved adept at gaming this system.[23]

Our parents and grandparents built the Medicare system, and hundreds of millions of Americans were well-served by it over the last half century. Now it's our job to strengthen Medicare for future generations, not break it into pieces and turn it over to the insurance industry. Congress has the power to ensure that Medicare remains financially sound. Congress has a range of ways to trim Medicare's costs, reduce waste and inefficiencies, and raise additional revenue to save public funds without privatizing Medicare and shifting more costs to vulnerable Americans.

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[18] CBO, Lessons from Medicare's Demonstration projects on Disease Management, Coordinated Care, and Value-Based Payment. January 18, 2012.
[19] National Center for Education Statistics, "The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy." September 2006.
[20] Kaiser Medicare Chartbook, 2010, 4th Edition, Figure 1.7.
[21] Van de Water, Paul N. "Converting Medicare to Premium Support would Likely Lead to Two-Tier Health Care System." Center for Budget and Policy Priorities. Sept. 26, 2011.
[22] Aaron, Henry and Austin Frakt, "Why Now Is Not the Time for Premium Support" New England Journal of Medicine, March 8, 2012.
[23] Jason Brown, Mark Duggan, Ilyana Kuziemko, and William Woolston, "How does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program." NBER Working Paper No. 16977, April 2011.

May 11, 2012

The Honorable Wally Herger
Chairman
U.S. House Ways and Means Subcommittee on Health
Washington, DC 20515

Dear Chairman Herger:

Mr. Chairman, I am submitting this statement on behalf of the members of the Healthcare Leadership Council (HLC). The HLC is comprised of chief executives of the nation's leading healthcare companies and organizations, representing virtually all sectors of American healthcare. It has long been a priority of HLC members to protect the long-term sustainability of the Medicare program and to ensure that beneficiaries have access to affordable, high-quality, innovative healthcare.

There is no question that the Medicare program, as it exists today, cannot be sustained for future generations. Each day, 7,500 baby boomers are joining the rolls of Medicare and, on average, each of these beneficiaries is receiving three dollars worth of healthcare services for every one dollar they paid in payroll taxes. In 1965, when Medicare was created, the ratio of active workers-to-beneficiaries was 19-to-one. By 2030, there will be only two taxpaying workers supporting each beneficiary.

These statistics tell us that structural reform of the Medicare program is imperative. The current fee-for-service program in which the vast majority of beneficiaries are enrolled does not sufficiently incentivize value, cost-effectiveness, or positive patient outcomes. It is a program that pays for volume of healthcare services, but not necessarily for value-driven care.

There are different options available to address Medicare's fiscal crisis. One is, of course, simply to reduce the amount of money the government pays for healthcare goods and services. When provider payments are reduced, however, beneficiaries pay the price. Already, many physicians place limitations on the number of Medicare patients they will treat because of the program's comparably low reimbursement rates. According to a 2010 American Medical Association survey, 31 percent of primary care physicians already restrict the number of Medicare patients they see. Cutting payments for pharmaceutical products and medical devices will simply deprive seniors of access to lifesaving and life-improving healthcare innovations.

This is the primary flaw in the Independent Payment Advisory Board (IPAB) concept, which some cite as an answer to Medicare's financial challenges. Washington cannot simply make

arbitrary cuts in Medicare expenditures without adversely affecting the access to care and quality of care provided to Medicare-dependent seniors and disabled citizens.

Many tout the much-needed delivery system reforms that were part of the Patient Protection and Affordable Act (PPACA). While we agree that these reforms are a step in the right direction, we do not believe that they are enough; nor will these changes offer the array of choice that would be available to beneficiaries through a Medicare exchange model, similar to the Federal Employees Health Benefits Plan (FEHBP).

A more patient-centered approach to improving Medicare would involve using the power of consumer choice to drive value, quality, and positive outcomes. We support the concept of empowering Medicare beneficiaries with greater control over their own healthcare decisionmaking.

To be more specific, HLC has been on record supporting an approach that would give Medicare beneficiaries the option of remaining in conventional fee-for-service Medicare or moving into a competitive exchange in which multiple health plans would compete for beneficiary loyalties by offering high-quality coverage options at affordable premium rates. In order for such a competitive exchange to be viable, plans and providers would have to emphasize both quality and cost-efficiency, as well as ensuring affordability, especially to attract individuals with lower incomes.

This approach has worked successfully in FEHBP, under which members of Congress and federal workers choose from a wide range of competing health plans. The concept has also worked well in the implementation of the Medicare Part D prescription drug program. In Part D, offering seniors a choice of plans has resulted in much lower-than-projected program costs, affordable monthly premiums, and extraordinarily high beneficiary satisfaction rates.

The consumer choice approach will also be utilized in the state-based health insurance exchanges that serve as a cornerstone of PPACA.

Leaving aside the ethical question of whether seniors should have the same power of consumer choice that so many others enjoy, it appears clear that the Medicare program would gain greater sustainability from this type of reform. In order to convince beneficiaries to shift from fee-for-service Medicare to a competitive exchange, plans would have to offer affordable premiums and an appealing scope of coverage. Health providers would innovate to provide high-quality care in an environment that emphasizes cost-efficiency.

This is far preferable to an alternative in which arbitrary across-the-board cuts are made by government fiat, forcing healthcare providers to further restrict beneficiary access to care.

The fact is, policymakers are going to have to choose one of these directions. It is a fallacy to insist that we can maintain the Medicare program exactly as it exists today. Even the most recent Medicare Trustees report that projects program insolvency in the year 2024 is painting an unrealistically rosy scenario. As CMS chief actuary Richard Foster has pointed out, that projection is based on a scheduled 31 percent reduction in Medicare physician payment rates in 2013 that almost certainly will not occur. This tells us that the need to reform the program is even more urgent than commonly assumed.

Chairman Herger, we applaud you and your colleagues for shining a spotlight on this vitally important issue. It is imperative that Congress begin the process to reform, improve, and

strengthen the Medicare program. We strongly urge Congress to develop reforms that are patient-centered, that provide care that is both accessible and high-quality, that gives patients access to lifesaving medical innovations, and that sets Medicare on a path toward long-term sustainability instead of the short-term relief offered by arbitrary budget cuts. The Healthcare Leadership Council looks forward to working with you on this critical priority.

Sincerely,

Mary R. Grealy
President

National Committee to Preserve Social Security & Medicare
Trusted • Independent • Effective

United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
Hearing on "Medicare Premium Support Proposals"
Friday, April 27, 2012

Mr. Chairman and Members of the Committee:

I am Max Richtman, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare, and I appreciate the opportunity to submit this statement for the record. With millions of members and supporters across America, the National Committee is a grassroots advocacy and education organization devoted to preserving and promoting Social Security and Medicare. As you know, these programs are the foundation of financial and health security for older Americans. Today, I will address our concerns about the negative impact of Medicare premium support proposals on current and future beneficiaries and suggest alternative ways to improve Medicare's long-term financial solvency.

Recently, the National Committee contacted all Members of Congress to advise them of our opposition to H. Con. Res. 112, the House Budget Resolution for Fiscal Year 2013, which privatizes Medicare over time and achieves savings for the federal government through a premium support system that would shift costs to Medicare beneficiaries and others. Beginning in 2023, when people become eligible for Medicare they would not enroll in the current program which provides guaranteed benefits. Rather, they would receive a voucher, also referred to as a premium support payment, to be used to purchase private health insurance or traditional Medicare through a Medicare Exchange.

The amount of the voucher would be determined each year when private health insurance plans and traditional Medicare participate in a competitive bidding process. The amount of the voucher would be equal to what the second-least-expensive private plan or traditional Medicare agreed to accept to cover Medicare beneficiaries. Seniors choosing a more expensive plan would be required to pay the difference between the voucher and the plan's premium, which could limit lower-income beneficiaries' access to certain plans. Those choosing a less-costly plan would receive a rebate. Under Chairman Paul Ryan's budget resolution, the annual growth in Medicare spending is limited to gross domestic product (GDP) + 0.5 percent, a rate likely to be lower than the growth in health costs. If spending exceeded this amount beneficiaries would be subject to additional out-of-pocket costs. That is because the amount the federal government provides for their voucher would be limited.

Chairman Ryan's budget resolution calls for private plans to provide benefits that are at least actuarially equivalent to the benefit package provided by fee-for-service Medicare. This gives private companies the ability to tailor their plans to attract the youngest and healthiest seniors, even if payments are "risk adjusted" to take health status into account, which would leave traditional Medicare with older and sicker beneficiaries. Their higher health costs could lead to

higher premiums that people would be unable or unwilling to pay, resulting in a death spiral for traditional Medicare. This would adversely impact people age 55 and older, despite Chairman Ryan's assertion that nothing will change for them, as well as people currently enrolled in traditional Medicare.

The Ryan proposal establishes accounts for low-income Medicare beneficiaries, likely those people eligible for Medicare and Medicaid, to use to pay premiums, co-payments and other out-of-pocket costs. However, it is unclear what the amount of assistance would be or if it would adequately cover out-of-pocket expenses. In addition, the plan applies current means-testing thresholds for Medicare Part B and D premiums for higher-income beneficiaries so that they would continue to have higher costs in the privatized Medicare system.

In addition to privatizing Medicare over time, the Ryan budget would increase the age of eligibility for Medicare from 65 to 67 by increasing it two months per year from 2023 to 2034. The Ryan budget also calls for repealing provisions in the Affordable Care Act (ACA), which will make insurance available and more affordable for 65 to 67 year olds. Without the guarantees in the ACA, such as requiring insurance companies to cover people with pre-existing medical conditions and to limit age rating, it would be very difficult and expensive for older people who would no longer be eligible for Medicare coverage to purchase private insurance. Repealing the ACA would also take away improvements already in place for Medicare beneficiaries - closing the Medicare Part D prescription drug coverage gap, known as the "donut hole;" providing preventive screenings and services without out-of-pocket costs; and providing annual wellness exams.

Action is needed to strengthen the long-term solvency of Medicare, but it is important to remember that Medicare's costs on a *per capita* basis are growing more slowly than private health care costs. Costs will continue to increase because of general health care inflation and the number of people becoming eligible for Medicare as the baby boomers reach age 65. Any dialogue about Medicare solvency must address ways to control overall health care inflation while improving the quality of care being provided.

The National Committee to Preserve Social Security and Medicare supports measures to improve the Medicare program and its financing *without* taking away guaranteed benefits or shifting additional costs to beneficiaries, the majority of whom already have high out-of-pocket health care costs and cannot afford to pay more. There are many ways to address the rising cost of Medicare and improve the program without dismantling Medicare and making health care costs unaffordable for many older and disabled Americans. These include:

- Implementing reforms in the Affordable Care Act (ACA), beyond provider payment reductions, that are designed to improve quality and reduce unnecessary spending. These reforms include programs that bolster primary care, establish Accountable Care Organizations, provide for bundled payments, and reduce hospital readmissions. The ACA reforms should be given time to succeed before possibly destroying the current Medicare program, which works well for so many seniors.

- Extending Medicaid rebates for drugs used by beneficiaries who are dually eligible for Medicare and Medicaid.
- Directing the Secretary of Health and Human Services to negotiate prescription drug prices in Part D, which could save hundreds of billions of dollars.
- Offering a drug benefit in traditional Medicare, which would lower costs for beneficiaries and taxpayers, in part due to Medicare's lower administrative costs.
- Reducing payments to private Medicare Advantage plans to 100 percent of what it costs traditional Medicare to provide care for the same beneficiary.

Thank you again for this opportunity to submit our views on Medicare premium support proposals. As you know, Medicare is a lifeline for many seniors in our country, and we at the National Committee to Preserve Social Security and Medicare will continue to work with our members, as well as policymakers, to ensure that the program remains strong for all generations. This means opposing premium support proposals that are structured to reduce federal spending by increasing costs for Medicare beneficiaries, and supporting reforms, such as those included in the *Affordable Care Act*, that will improve both Medicare's financing and the care beneficiaries receive.

Max Richtman

Max Richtman
President and CEO

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