FULFILLING A LEGAL DUTY: TRIGGERING A MEDICARE PLAN FROM THE ADMINISTRATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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FULFILLING A LEGAL DUTY: TRIGGERING A MEDICARE PLAN FROM THE ADMINISTRATION

TUESDAY, JULY 12, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:05 p.m., in room 2154, Rayburn House Office Building, Hon. Trey Gowdy (chairman of the subcommittee) presiding.

Present: Representatives Gowdy, Gosar, DesJarlais, Davis, Norton, Clay, Murphy and Cummings (ex officio).

Staff present: Ali Ahmad, deputy press secretary; Brian Blase, professional staff member; Robert Borden, general counsel; Drew Colliatie, staff assistant; Gwen D'Luzansky, assistant clerk; Linda Good, chief clerk; Christopher Hixon, deputy chief counsel, oversight; Sery E. Kim, counsel; Justin LoFranco and Cheyenne Steel, press assistants; Mark D. Marin, senior professional staff member; Ronald Allen, minority staff assistant; Jaron Bourke, minority director of administration; Yvette Cravins, minority counsel; Carla Hultberg, minority chief clerk; and Christopher Staszak, minority senior investigative counsel.

Mr. GOWDY. Welcome. This is a hearing entitled "Fulfilling a Legal Duty: Triggering a Medicare Plan from the Administration."

I would ask the first witness in a panel by himself to come forward.

Thank you, Mr. Blum.

Let me read the mission statement from the Oversight Committee. We exist to secure two fundamental principles. First, Americans have a right to know the money that Washington takes from them is well spent; and second, Americans deserve an efficient and effective government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold government accountable to taxpayers, because the taxpayers have a right to know what they get from their government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

I will recognize myself for an opening statement and then recognize the distinguished gentleman from Illinois Mr. Davis.

First I want to thank not just the first panel of witnesses, but all the witnesses for their time and willingness to share their insights, as well as thank all the guests in the audience. As part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress enacted a trigger provision, a statutory requirement to propose Medicare reform should certain conditions be met. Each year the Medicare trustees are required to include a Medicare funding warning in their annual report should general revenue funding exceed 45 percent of total Medicare revenue for the current year or is projected to exceed 45 percent for the subsequent 6 years. Should that warning be issued in consecutive years, the trigger mechanism would take effect requiring the President to submit legislation to Congress that would decrease the percentage of general revenue financing Medicare. Since 2006, every single annual report has included this warning.

The previous administration complied with this law. The current administration has not, and that is troubling on at least two fronts. Firstly and fundamentally, we are a Nation of laws. We don't have the luxury of picking and choosing which laws we like and which laws we do not like. The law is no respecter of title or station, it applies to all. So it is troubling the President, who is the Chief Executive of the branch charged with enforcing the laws, has not complied. And this failure to comply is troubling because we are witnessing firsthand right now the need for decisive leadership on the tough spending issues facing our country.

Making speeches isn't hard. Saying you have a plan when you don't have a plan isn't hard. What is hard is leading. What is hard is making tough decisions. That is what is statutorily, and indeed morally, required of leaders.

Without substantive reform Medicare will be insolvent in a decade. Costs are skyrocketing, and benefits are threatened by the unsustainable status quo. Something has to be done, and simply talking about the problems will no longer suffice. Abdicating this duty might be a good political strategy; it is not a good strategy for this country. We can hope for the leadership to resolve this difficult issue. That we can hope for. What we should never be forced to hope for is compliance with the law. Hence this hearing.

I now recognize the gentleman from Illinois, ranking member of the subcommittee, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman. And I want to thank you, first of all, for holding this very important hearing. As a matter of fact, this is an issue that I care deeply about, and for many different reasons.

For more than 45 years, Medicare has successfully provided access to health services for the elderly ages 65 and over and nonelderly people with disabilities. It currently covers 47 million Americans. Just think about it, 47 million Americans. Since July 30, 1965, when Lyndon Johnson signed the bill creating this fundamental health initiative, this program has evolved to reliably meet the demands of aging and medically vulnerable Americans who may not have had access to medical attention otherwise. Simply put, Medicare is the lifeline.

Given the political realities, I realize that certain well-thought-out improvements need to be made for Medicare to continue its

course. However, make no mistake, I, along with my Democratic colleagues, am committed to ensuring the viability and sustainability of Medicare without deep ideological-driven cuts with harmful consequences.

It is this same commitment that ensured that Congress worked actively for comprehensive health reform. The passage of the Affordable Care Act further improved upon the fiscal efficiencies necessary to ensure Medicare's continued existence.

On a personal note, I have been involved in health advocacy for over 35 years. I believe it fundamentally reveals the character of a Nation when it cares for its most vulnerable citizens, the elderly and the infirm. In my district I can attest that Medicare serves as an indispensable safety net for many of my constituents.

This discussion is a valid one, but it must be approached in a serious, thoughtful manner mindful of the sacrifices made by those who came before us. Seniors should not bear the burden of cost shifting disguised as reform.

I look forward to the testimony of all the witnesses. And I will just end, Mr. Chairman, by suggesting that if it was not for Medicare, many of the senior citizens that I personally know probably would not still be around, because oftentimes Medicare is the only stopgap between them and the grave. So if we talk about safety nets, there is nothing that can provide more safety than the opportunity for individuals who have reached an age where they cannot necessarily care for themselves to know that at the end of the day, they can get the medical services that they need.

I look forward to the hearing and yield back the balance of my time.

Mr. GOWDY. I thank the gentleman from Illinois.

I now recognize the gentleman from Maryland, the ranking member of the full committee, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I want to thank you for calling this hearing today. And I want to pick up where the ranking member of this subcommittee left off.

As the son of a mother who is 85 years old, I just watch her struggle through the difficulty of seeing her doctor retire and trying to help her find a new doctor. She found a new doctor, but even that was very taxing on her at 85 years old.

To pick up where Mr. Davis left off, and when I meet with people in my district, the seniors, and I ask them, you know, who has savings and who has pensions and whatever, most of them, all they have is Social Security and Medicare, that's it, period. So to put it more bluntly, without Medicare they would be—many of them would be dead, period.

There are 45 million people nationwide who depend on Medicare for their health care. For them and for millions of seniors who will come after them, it is vital that Congress ensure Medicare's long-term solvency. The Patient Protection and Affordable Care Act extended the Medicare Trust Fund solvency by 8 years, which is one of the many reasons I'm proud that I voted to enact this law, and I will go to my grave defending it.

By providing free, preventative screenings and reducing the cost of brand-name prescription drugs, the Affordable Care Act has already made a tremendous impact on seniors' health care and their

pocketbooks. The Affordable Care Act also addresses the escalating cost of health care by reforming Medicare's payment and delivery system to incentivize high-quality, better-coordinated care without inefficiencies and to fight fraud and abuse.

In contrast, the recent plan passed by my House Republican friends would eliminate Medicare as we know it. In a radical transformation they would wipe out Medicare's guaranteed benefits for seniors. They would also shift massive costs onto seniors, while doing nothing to address the real reasons behind the high cost of health care.

Under the Republican plan seniors aged 65 and 66 would be abandoned to find health care on their own or go without it. Seniors 67 and older would get a voucher from the government to pay a smaller and smaller share of their health care costs. But one of the questions that I posed to so many, and I've never received a satisfactory answer, Mr. Chairman, is that if I have a senior at 65 years old with diabetes and its companion heart disease, who is going ensure them? I don't care how much money you've got, who is going to ensure them?

The nonpartisan Congressional Budget Office estimated that the Republican plan would more than double out-of-pocket costs for seniors. Right now seniors pay about 25 to 30 percent. Under the Republican plan they would pay 68 percent with no money, by the way. The Center for Economic Policy Research calculates that the Republican plan would shift costs of up to $4.9 trillion onto seniors. For the individual senior citizen, that would amount to an average of $13,368 per year.

Mr. Chairman, the Republican plan is cruel, and it is sadly a cruel betrayal of our Nation's seniors. It would have a profoundly negative impact on the health of those elderly, it would be detrimental to the Nation's economy, and it would impair the living standards of seniors and their children, who will be called upon to take over when the government abandons them. This radical—and again, I go back to if they can get insurance.

This radical plan is not inevitable, and Democrats in Congress will fight tooth and nail to help protect our Nation's seniors from this abomination. At the same time we will seek commonsense measures to secure runaway medical inflation rather than taking away medical care from people who need it.

And I agree with the ranking member, there are things that have to be done with regard to Medicare. Nobody is saying it's either one way or the highway. But we have to do those things that are sensible, and we have to do those things—we have to treat this as if we are the most skilled heart surgeon performing the most delicate operation so that we do the treatment and give the reform that will allow Medicare to live as opposed to allow the patient to die.

And so I look forward to the testimony today. I want to thank our witnesses. And again, Mr. Chairman, I think this is a grand opportunity for us to address this issue. And with that I yield back.

Mr. GOWDY. I thank the gentleman from Maryland.

[The prepared statement of Hon. Elijah E. Cummings follows:]

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Opening Statement

Ranking Member Elijah E. Cummings
"Fulfilling a Legal Duty: Triggering a Medicare Plan from the Administration"

July 12, 2011

Chairman Gowdy and Ranking Member Davis, thank you for holding today's hearing.

There are 45 million people nationwide who depend on Medicare for their healthcare. For them, and for the millions of seniors who will come after them, it is vital that Congress ensure Medicare's long-term solvency. The Patient Protection and Affordable Care Act extended the Medicare trust fund's solvency by eight years, which is one of the many reasons I am proud that I voted to enact this law.

By providing free preventative screenings and reducing the cost of brand name prescription drugs, the Affordable Care Act has already made a tremendous impact on the seniors' healthcare, and their pocketbooks.

The Affordable Care Act also addresses the escalating costs of health care by reforming Medicare's payment and delivery system to incentivize high-quality, better coordinated care, to root out inefficiencies, and to fight fraud and abuse.

In contrast, the recent plan passed by House Republicans would eliminate Medicare as we know it. In a radical transformation, they would wipe out Medicare's guaranteed benefits for seniors. They would also shift massive costs onto seniors, while doing nothing to address the real reasons behind the high costs of healthcare.

Under the Republican plan, seniors age 65 and 66 would be abandoned to find health care on their own or go without it. Seniors 67 and older would get a voucher from the government to pay for a smaller and smaller share of their healthcare costs each year.

The non-partisan Congressional Budget Office estimated that the Republican plan would more than double out-of-pocket costs for seniors. Right now, seniors pay about 25-30%; under the Republican plan, they would pay 68%.

The Center for Economic Policy Research calculates that the Republican plan would shift costs of up to $4.9 trillion onto seniors. For the individual senior citizen, that would amount to an average of $13,368 per year.

Mr. Chairman, the Republican plan is a cruel betrayal of our nation's seniors. It would have a profoundly negative impact on the health of the elderly, it would be detrimental to the nation's economy, and it would impair the living standards of seniors and their children, who will be called on to take over when the government abandons them.

This radical plan is not inevitable, and Democrats in Congress will fight tooth and nail to help protect our nation's seniors from this abomination. At the same time, we will seek common-sense measures to curb run-away medical inflation, rather than taking away medical care from people who need it most.

I look forward to the testimony of the witnesses here today.

Contact: Ashley Etienne, Communications Director, (202) 225-5051.

Mr. GOWDY. It is now my pleasure to introduce Mr. Jonathan Blum, who is the Deputy Administrator and Director, Center for Medicare and—Centers for Medicare and Medicaid Services.

Pursuant to committee policy, I would ask Mr. Blum to please rise and let me administer an oath.

[Witness sworn.]

Mr. GOWDY. May the record reflect that the witness answered in the affirmative.

Mr. Blum, there are a series of lights hopefully somewhere. They mean what they traditionally mean outside of committee hearings. So with that we would recognize you for your 5-minute statement.

STATEMENT OF JONATHAN BLUM, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. BLUM. Great. Thank you, Chairman Gowdy, Ranking Member Davis and members of the committee. I am pleased to be here today to talk about our efforts to strengthen the Medicare program.

I would like to make three main points during my 5 minutes. First, the Affordable Care Act has made substantial improvements to Medicare's overall finances. The Affordable Care Act will reduce Medicare spending by over $500 billion over the next 10 years.

Many of the savings provisions included in the Affordable Care Act came from proposals that were part of the President's first budget submission to Congress in 2009. These proposals included a payment change to promote accountable care organizations to participate within the Medicare program, bundled payments to promote greater care coordination and greater efficiency to our payments, payment reductions to certain health care providers and incentives for hospitals to improve quality. Many of these saving provisions have been already implemented, so the savings are real, and CMS is on track to implement the remaining savings provisions on time.

This year's Medicare Trustees Report confirmed the Affordable Care Act's impacts on the program's overall solvency. The Part A trust fund solvency has been extended by 8 years. The 45 percent trigger threshold will be met by 2013. Projected per capita spending will be 2.9 percent over the next 10 years, significantly lower than the previous 10 years. The cost curve, at least in the short run, has been bent downward. Not only do these changes reduce taxpayers' burdens, but they lower costs for Medicare beneficiaries through lower copayments and premiums.

The second point that I want to make today is that reducing Medicare costs is one of CMS's greatest priorities, highest priorities. We have made significant new investments in reducing waste, fraud and abuse. Through our partnerships with law enforcement agencies, billions of dollars have been recovered back to the trust funds.

We have also implemented on January 1st the first round of competitive bidding for medical supplies such as power wheelchairs. Through this competitive bidding program, Medicare will pay an average of 32 percent less than it previously paid for power wheelchairs, oxygen tanks and other durable equipment. That 32 percent

is an average figure. The program will save billions of dollars for taxpayers and beneficiaries when fully phased in.

We have also closed loopholes and reformed our payment systems to ensure that we pay accurately for providers such as skilled nursing facilities, home health agencies and physician services. CMS will continue to use its rulemaking authorities to ensure we pay as accurately and fairly as possible.

And the third point I would like to make today is that Medicare benefits are stronger due to the Affordable Care Act and our work at CMS. The Medicare Part D doughnut hole is being phased out by 2020, and this year those that do fall into the doughnut hole will save hundreds of dollars on their out-of-pocket costs for prescription drugs. This year the program began to offer free cost sharing for certain preventive benefits to keep seniors healthier for longer periods of time, and the Medicare Advantage program continues to grow—not shrink, but to grow—while offering average lower premiums.

Clearly we have more work to do to ensure a sustainable program for the long-term future. We look forward to working with the Congress to ensure we have the strongest program possible. I would be happy to answer your questions.

Mr. GOWDY. Thank you, Mr. Blum.

[The prepared statement of Mr. Blum follows:]

U.S. House Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census and the National Archives

Hearing on CMS Efforts to Strengthen the Medicare Program
July 12, 2011

Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee, thank you for the invitation to discuss efforts to preserve and strengthen the Medicare program. The Administration is committed to protecting and strengthening the Medicare program, which will provide care to approximately 50 million Americans in 2012.

Since its passage more than 16 months ago, the Affordable Care Act has been reducing Medicare costs while improving the overall quality of care provided to Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) has already implemented many of the savings provisions contained in the Affordable Care Act, extending the solvency of Medicare. These provisions include slowing the growth in Medicare costs through smaller annual updates in provider payments and reducing overpayments to Medicare Advantage (MA) plans while creating new incentives for MA plans to improve the care they offer. Further, we have plans to reduce hospital-acquired conditions and preventable hospital readmissions. The Affordable Care Act created the Center for Medicare and Medicaid Innovation (the Innovation Center) to test and evaluate innovative payment and service delivery models. In addition, the Affordable Care Act is building a stronger Medicare program by providing new preventive benefits, improving access to life-saving prescription drugs, and increasing support for primary care. CMS is also streamlining and building a more efficient Medicare program by decreasing fraud, waste, and abuse in our programs, implementing competitive bidding for durable medical equipment, and improving how Medicare pays for physicians' services. Due to many of these changes made by the Affordable Care Act, the 2011 Trustees report notes that general revenue as a share of Medicare funding is projected to fall below the 45 percent threshold from 2013 through 2021 – less than two years from now.

True improvements to our nation's health care system, including the Medicare program, must involve fundamental changes to the way that health care is delivered and financed – changes that will improve quality, better coordinate care, and lower costs.

The Affordable Care Act's Historic Changes Will Reduce Medicare Costs

The Affordable Care Act includes new policies and authorities that reduce Medicare spending and make important delivery system reforms, while improving Medicare benefits for seniors and people with disabilities. These important changes are projected to decrease Medicare spending by approximately $500 billion over ten years, producing savings for the taxpayers and prolonging the life of the Medicare Hospital Insurance Trust Fund until 2024. From a historical perspective, over the past decade, Medicare spending has grown at an overall annual rate of 7.6 percent. However, with the reforms and new provisions in the Affordable Care Act, which bend the cost curve downward, current law projections show Medicare costs rising at a slower rate of 5.3 percent —or 2.9 percent per capita—over the next ten years. This is about the same rate as the growth in the general US economy. These changes will also benefit people with Medicare by reducing their premiums and other out-of-pocket costs.

Smaller Provider Payment Updates: The Affordable Care Act applies an annual productivity adjustment to Medicare rates for most categories of providers paid under Medicare's traditional fee-for-service program. These adjustments mean that affected providers' annual payment updates will be adjusted by a factor equal to a ten-year average of productivity growth in the economy at large.

Leveling the Playing Field for Medicare Advantage Plans and Promoting Quality: In 2011, MA plans are paid on average about 10 percent more than the costs of care provided by the traditional Medicare program.[1] The Affordable Care Act phases-out these extra payments so that plans will be paid on average what it costs to provide care through the traditional fee-for-service program. At the same time, CMS is implementing new payment incentives that will promote quality improvement and reward plans that provide the greatest quality outcomes. Despite the

[1] http://www.medpac.gov/documents/Mar11_EntireReport.pdf

payment reductions, enrollment in MA plans continues to grow – enrollment increased 6 percent from 2010 to 2011 and average MA premiums declined by 6 percent from 2010 to 2011.

Reimbursement Incentives to Improve Safety and Quality:

- Specific focus on Hospital-Acquired Conditions (HACs): These conditions consist of complications, including infections, that patients acquire while receiving care that is supposed to help them. Not all HACs are preventable, but a great number can be avoided. For example, the Centers for Disease Control and Prevention (CDC) has estimated that each year, almost 100,000 Americans die and millions suffer from hospital-acquired infections alone.[2] In addition to pain, suffering, and sometimes death, these HAC complications could add as much as $45 billion to hospital costs paid each year by taxpayers, insurers, and consumers.[3] The Department of Health & Human Services' Office of the Inspector General has reported that 44 percent of adverse events experienced by Medicare beneficiaries in the October 2008 sample month were preventable, and that these complications cost the Medicare program an extra $119 million in that one month alone.[4]

  We know of hospitals in this country that, through improvements in their health care processes, have virtually eliminated some forms of infections that other hospitals still think are inevitable. To create incentives for hospitals to prevent such infections and other adverse conditions, the Affordable Care Act includes a Medicare payment reduction for hospitals in the top quartile of all hospitals with regards to selected hospital-acquired conditions under the inpatient prospective payment service system beginning in fiscal year 2015. Consistent with our commitment to transparency, information for consumers, and the Affordable Care Act, the Secretary will publically report information regarding HACs of each affected hospital on the Hospital Compare website. Those hospitals will

[2] Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. March 2007. http://www.cdc.gov/ncidod/dhqp/pdf/hicpac/infections_deaths.pdf
[3] The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, March 2009, http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.
[4] Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, November 2010, http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.

have an opportunity to review, and submit corrections for, the information to be made public prior to the information being publically reported.

- Reducing unnecessary hospital readmissions: We know that about one in every five Medicare beneficiaries discharged from the hospital will be re-admitted within 30 days of discharge. The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare spends $12 billion annually on potentially preventable readmissions.[5] Proper attention to care transitions, coordination, outreach, and patient education and support could prevent unnecessary readmissions and allow at-risk patients to recover at home, where they would prefer to be, rather than reentering the hospital with complications. The Affordable Care Act provides for a payment adjustment for inpatient hospital services to encourage the reduction of certain readmission rates and also provides financial incentives for certain hospitals partnering with community-based organizations to improve transitional care processes. Beginning in FY 2013, Medicare inpatient prospective payments to a hospital will be reduced based on the hospital's percentage of preventable Medicare readmissions for three high volume procedures. Per the Affordable Care Act, the readmission rate information for all patients in each hospital participating in the program will be publicly available online.

Delivery System Reforms through the Center for Medicare and Medicaid Innovation: The Affordable Care Act provides CMS a new cross-cutting resource to accelerate reforms of the delivery system and to potentially make Medicare and Medicaid more efficient. The Center for Medicare and Medicaid Innovation (the Innovation Center) will test and evaluate innovative payment and service delivery models. In doing so, the Innovation Center will work collaboratively with relevant Federal agencies, clinical and analytical experts, local, national, and regional providers, States, and beneficiary organizations to identify and promote systems changes that could improve quality and outcomes for patients while containing or reducing program expenditures.

[5] Medicare Payment Advisory Commission (MedPAC) Report to the Congress, June 2007. (2005 data).

Under these new authorities, the Administration recently launched the *Partnership for Patients: Better Care, Lower Costs*, a new, national public/private effort to help save thousands of American lives and billions of dollars for taxpayers, employers, and hospitals by working over the next three years to reduce preventable injuries and complications in patient care.

The two goals of this new partnership are:

- Keep hospital patients from getting injured or sicker: By the end of 2013, decrease preventable hospital-acquired conditions by 40 percent compared to 2010.
- Help patients heal without complication: By the end of 2013, decrease preventable complications during a transition from one care setting to another, so that all readmissions would be reduced by 20 percent compared to 2010.

Achieving these goals would mean over three years approximately two million fewer injuries to hospital patients, more than 60,000 lives saved, and avoiding more than 1,600,000 hospital readmissions due to complications prevented. In the process of pursuing these goals we will develop, study, and refine models for spreading effective health care practices that will potentially translate to future efforts at large-scale improvement.

Building a Stronger Medicare Program

While reducing Medicare costs, the Affordable Care Act has strengthened the Medicare program for its beneficiaries. Beneficiaries are already receiving tangible benefits from the provisions that have been implemented.

New Preventive Benefits for People with Medicare: Thanks to the Affordable Care Act, people with Medicare are eligible to receive critical preventive care, like mammograms and colonoscopies, with no coinsurance or deductible. Beneficiaries also have access to a new annual wellness visit starting this year. As of June 10, about 5.5 million people with Medicare have accessed one or more preventive measures and at the end of June, we launched a new awareness effort– *Share the News, Share the Health* – to highlight Medicare's preventive benefits and encourage Medicare beneficiaries to take advantage of these potentially lifesaving services. Improving access to preventive care can improve early detection and treatment options,

potentially reducing the cost of care and improving the health of our Medicare population in the long run.

Improving Medicare Beneficiaries' Access to Life-saving Prescription Drugs: As a result of new provisions in the Affordable Care Act, people with Medicare have already received relief from the cost of their prescription medications. Beneficiaries now automatically receive a 50 percent discount on covered brand-name drugs in the Part D coverage gap, or "donut hole," and almost half a million individuals enrolled in Medicare's prescription drug benefit who have reached the donut hole have saved an average of $545 each, for total savings of more than $260 million so far this year. People with Medicare Part D will pay a smaller share of their prescription drug costs in the coverage gap every year from now until 2020, when the coverage gap will be closed.

For 2010, nearly 4 million eligible seniors and people with disabilities who reached the donut hole received help through a one-time, tax-free $250 rebate check to help reimburse them for out-of-pocket drug costs. In addition to improved coverage, premiums for beneficiaries enrolled in Medicare Part D beneficiaries have stayed essentially flat in 2011. Average monthly premiums for Part D coverage rose less than $2 in 2011, from $29 in 2010 to around $30.50 this year.

Improvements in Medicare Advantage: This year, we have improved our oversight and management of the MA program. The results for the 2011 plan year show that when CMS strengthens its oversight and management of MA plans, people with Medicare have clearer plan choices that, on average, offer improved protections and stable benefits at lower premiums. Contrary to projections of enrollment decline, in 2011 MA enrollment is up 6 percent and average premiums are down 6 percent compared to 2010, while benefit and cost-sharing levels remain roughly the same. Access to MA remains strong, as more than 99 percent of Medicare beneficiaries have a choice of MA plans as an alternative to Original Medicare. We expect continued strong enrollment growth in MA plans in 2012.

Increased support for primary care: Thanks to the Affordable Care Act, physicians have better incentives to provide vital primary care services to Medicare beneficiaries. Beginning January 1, 2011, the Affordable Care Act provides for new 10 percent bonus payments for primary care services furnished by a primary care practitioner and for major surgical procedures furnished by a general surgeon in a health professional shortage area. Primary care practitioners in family medicine, internal medicine, geriatric medicine or pediatric medicine, as well as general surgeons, nurse practitioners, clinical nurse specialists, and physician assistants are eligible for these new incentive payments.

Effective Management of the Medicare Program

In addition to implementing the new benefits and changes included in the Affordable Care Act, CMS strives for continual improvement in our day-to-day operations. We are making a number of improvements in the Medicare program to make the program run more efficiently and effectively.

Strengthening Program Integrity — Preventing Fraud, Waste, and Abuse:

This Administration has put an unprecedented focus on reducing fraud and improper payments, and is making progress towards that end. By 2012, the President has committed to cutting the Medicare fee-for-service error rate in half. Enhanced screening requirements for providers and suppliers to enroll in Medicare, Medicaid, and the Children's Health Insurance Program, along with oversight controls such as a face-to-face requirement for home health and hospice services and the authority to impose temporary enrollment moratoria will allow us to better focus our resources on addressing the areas of greatest concern and highest dollar impact. We are also adopting predictive modeling technology used by the private sector to prevent improper payments and fight fraud in our programs.

Building on these new fraud fighting authorities included in the Affordable Care Act, the President's FY 2012 Budget Request proposes a variety of additional legislative initiatives to preserve the Medicare Trust Funds by preventing and detecting fraud, waste, and abuse. These proposed enhanced authorities include:

- Pre-payment, or earlier, review of power wheelchair claims, which would help lower the high error rate associated with this equipment;
- Retaining a portion of collections from Recovery Auditors, which would allow CMS to implement additional corrective actions to prevent future improper payments;
- Additional authority to exclude providers affiliated with sanctioned entities from Federal health care programs;
- Limits on the discharge of health care fraud debt in bankruptcy proceedings, to ensure that fraudsters cannot exploit bankruptcy law to avoid repaying the Federal government;
- Penalties for the illegal distribution of beneficiary identification numbers, to help deter individuals and enterprises that sell these ID numbers for use in fraudulent billing schemes; and
- Requiring the recovery of erroneous payments made to insurers participating in Medicare Advantage.

Finally, through the Health Care Fraud Prevention and Enforcement Action Team, or "HEAT," CMS has joined forces with our law-enforcement partners at the Department of Justice and the Office of Inspector General to collaborate more effectively and to enhance our efforts to prevent, identify, and prosecute health care fraud.

Competitive Bidding for Durable Medical Equipment, Prosthetics, Orthotics and Supplies: CMS has implemented Round 1 of competitive bidding for durable medical equipment in 9 areas around the country and the program has been successful, by all measures. Before moving forward, CMS made a number of improvements to help suppliers better navigate the bidding process. We also made great efforts to ensure small businesses were a part of the competitive bidding program, and those efforts were achieved: 51 percent of the contract suppliers are small businesses. Competitive bidding has reduced prices by an average of 32 percent below previous prices, resulting in lower out-of-pocket costs for beneficiaries, and billions of savings for the Medicare program. Beneficiaries are now receiving affordable durable medical equipment from well-vetted suppliers, all with no change in beneficiary access and health outcomes so far. CMS is working to expand the program to an additional 91 areas by 2013.

End Stage Renal Disease Bundled Payment System: The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required CMS to develop a new, fully bundled End Stage Renal Disease (ESRD) prospective payment system for renal dialysis services furnished to Medicare beneficiaries on or after January 1, 2011. Under the new payment system, notwithstanding a four-year transition period, Medicare makes a single prospectively determined payment to the dialysis facility that pays for all items and services furnished during a dialysis session, including ESRD drugs and other items and services that were separately payable under the previous payment methodology (with the exception of certain oral drugs until 2014).

The new ESRD bundled payment system seeks to target payments and incentives towards better patient care and clinical outcomes. The new system promotes efficiency and flexibility for dialysis facilities thereby increasing desirable clinical outcomes. Most importantly, the new system eliminates the financial incentives to over-utilize separately billable items to maximize facility profits. In addition, the new system focuses payments towards more costly patients, thereby reducing incentives to "cherry pick" patients.

Bundled ESRD payments also seek to ensure high quality of care for patients receiving dialysis. MIPPA required an ESRD quality incentive program (QIP) along with the ESRD bundled payment system. The QIP is designed to improve patient outcomes by establishing payment incentives for dialysis facilities to meet performance standards established by CMS.

Reforms to the Physician Fee Schedule: On July 1, 2011, CMS issued a proposed rule that would update payment policies and rates for physicians and non-physician practitioners for services paid under the Medicare Physician Fee Schedule in calendar year 2012. Changes in the proposed rule include:

- Potentially misvalued code initiative: CMS is significantly expanding the potentially misvalued code initiative, an effort to ensure Medicare is paying appropriately for physicians' services and more closely managing the payment system. This year, CMS is focusing on the highest volume and dollar codes billed by physicians and on the evaluation and management codes to determine whether these codes are appropriately valued. In the past, CMS has targeted specific codes for review that may have affected a

few procedural specialties like cardiology, radiology, or nuclear medicine but not taken a look at the highest expenditure codes across all specialties.

- Advanced imaging services: CMS is proposing to extend the multiple procedure payment reduction (MPPR) policy that currently applies to the technical component (TC) of advanced imaging services to the professional component (PC) of those services – specifically, computed tomography (CT) scans, magnetic resonance imaging (MRI), and ultrasound. This proposal reflects CMS' belief that there are efficiencies in physician work, especially in the pre- and post-service periods, when more than one advanced imaging service is furnished to a patient in one day. This proposal, which would affect about 100 types of services, would be the first time the imaging MPPR was applied to the physician work component of services, though an MPPR has long been applied to the work component of surgical procedures. Under this proposed policy, full payment would be made for the most expensive procedures (TC and PC), and both the TC and the PC payment would be reduced by 50 percent for subsequent procedures furnished to the same patient, on the same day, in the same session. CMS estimates that this would reduce payments for these services by about $200 million, which would be redistributed to other services paid under the Medicare physician fee schedule.

The Medicare "45 Percent Trigger"

CMS has undertaken a series of initiatives to stabilize Medicare's long-term finances, through implementation of reforms authorized in the Affordable Care Act and ongoing changes in the program to promote more efficient operations. When discussing long-term Medicare solvency, it is useful to remember that three sources of revenue finance nearly all of Medicare's expenses: payroll taxes, which pay for most of Part A (hospital insurance); beneficiary premiums, which cover about 25 percent of Part B (outpatient care) and Part D (prescription drug coverage) costs; and general revenues, which offset the remaining costs, including 75 percent of Parts B and D. As health care is increasingly delivered in outpatient settings and with the 2006 start of the prescription drug benefit, general revenues as a share of total Medicare funding have grown over time.

The Medicare Prescription Drug, Improvement, and Modernization Act – best known for establishing Medicare Part D – contained a provision commonly referred to as the "45 percent trigger." The Act requires the Medicare Trustees to issue a "funding warning" if, for two years in a row, they project that general revenues will exceed 45 percent of Medicare funding in the current year or in any of the next 6 years. While it is true that the 2011 Trustees' report issued a funding warning, it notes that general revenue as a share of Medicare funding is projected to fall below the 45 percent threshold from 2013 through 2021 "due to changes made by the ACA."[6]

Some argue that a "funding warning" is not the best way to understand Medicare's financial position, since the portion of Medicare costs financed by general revenues is misleading as a metric of Medicare solvency. Other metrics, including the rate of growth in Federal spending on Medicare, are more meaningful. For example, if Medicare spending increased sharply, but the increases were financed proportionately by general revenues and non-general-revenue sources, the 45 percent threshold would not be exceeded and the warning would not be triggered, even though Medicare solvency could be affected.

In addition, the formula used to construct the "general revenue" percentage does not treat all "savings" proposals equally, based on their effect on Medicare solvency. Proposals that increase beneficiary premiums, payroll tax revenues, or Social Security taxes help avoid triggering a funding, while policies that reduce overall program expenditures by the same amount – and reduce both the numerator and denominator of the formula – are less likely to have the same impact on lowering the proportion of Medicare financed by general revenues.

Rather than responding to a single metric that may not be a good measure of solvency, the Administration believes it is important to focus on how we can reduce the overall cost of Medicare to the Federal government and to beneficiaries, while increasing the value, efficiency, and quality of care provided to Medicare beneficiaries. The fact that a growing percentage of Medicare financing comes from general revenues is on its face no more problematic than the fact that financing for veteran's benefits or many other Federal programs comes from general

[6] 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf

revenues. Our real challenge is to improve Medicare's long-term sustainability by fundamentally changing our country's health care delivery and to lower its costs. Reducing costs, however, does not mean shifting them to beneficiaries or other payers – it means increasing the value of care received by people with Medicare.

Conclusion

One of CMS' priorities is to improve the quality and efficiency of health care for Medicare beneficiaries. We are confident that the reforms made by the Affordable Care Act, coupled with ongoing efforts to improve CMS programs and operations, will continue to ensure that Medicare remains strong for the beneficiaries who rely on it for their health care needs. Despite the improvements and progress that we have made, we recognize that protecting and improving the Medicare program will be an ongoing challenge and that we have more work to do. No one should doubt the Administration's ongoing commitment to ensuring that Medicare remains strong. We look forward to continuing to work with Congress on our ongoing efforts to preserve and protect Medicare for future generations.

Mr. GOWDY. I would say on behalf of all of us, votes are imminent, and all of us want to be good stewards of your time as well as the time for the second panel. I know that people have other commitments and other things to do. So we're going to ask questions until they call for votes, and then if we get back in time and you're still here, great; if not, then we want to be respectful of things other people have. So thank you. We apologize for that in advance.

Mr. Blum, what's the purpose of the trigger?

Mr. BLUM. The 45 percent trigger?

Mr. GOWDY. That's right.

Mr. BLUM. Well, the MMA, the Medicare Modernization Act of 2003, created a kind of additional solvency measure to assess the overall financing of the total Medicare program Parts A and Parts B.

Mr. GOWDY. And it requires the President to submit a plan to Congress, correct?

Mr. BLUM. The statute requires that the Medicare trustees issue a funding warning when certain conditions have been met.

Mr. GOWDY. Have those conditions been met?

Mr. BLUM. They were met starting as of 2006 or 2007.

Mr. GOWDY. Right. So according to Federal law, President Obama was supposed to submit a plan to this Congress to flip that 45 percent of general revenue funding for Medicare, correct?

Mr. BLUM. The 45 percent trigger has been met, will be met by 2013. The Affordable Care Act will——

Mr. GOWDY. That wasn't my question.

Mr. BLUM. The President has consistently submitted a budget to propose reductions to overall Medicare's financing. In 2009, the President submitted a historic budget framework to reduce——

Mr. GOWDY. So he doesn't take the position that is advisory, he takes the position that it is the law?

Mr. BLUM. I think the position that the administration takes is that reducing Medicare costs is one of our highest priorities.

Mr. GOWDY. Mr. Blum, I'm not asking you about priorities, I'm asking you about compliance with the law. Does this administration take the position that the trigger is advisory or mandatory?

Mr. BLUM. We take the position that reducing Medicare costs is our highest priority.

Mr. GOWDY. Mr. Blum, I'm probably not asking my question very artfully, so let me try it again. Is the trigger mandatory or discretionary, complying with it?

Mr. BLUM. The trigger is one measure of overall Medicare solvency. The President has proposed a budget in 2009. Many of those savings provisions were included within the Affordable Care Act and adopted in the Affordable Care Act.

Mr. GOWDY. So your position is that the Affordable Care Act or ObamaCare meets his requirements under that section for the trigger?

Mr. BLUM. My position today is that the President has continued to propose ideas and proposals to reduce Medicare spending, and as a result by 2013, in 2 years' time, the 45 percent threshold has been met.

Mr. GOWDY. Mr. Blum, I quit counting at number seven when I heard for the seventh time my colleagues refer to the Republican plan. And that's great, they can—that's the beautiful part about our Republic is that we can introduce ideas and criticize them, and heavens knows Paul Ryan's plan has certainly been scrutinized and criticized.

I wonder if the President's decision not to submit a plan to fix Medicare might be because he had the prescience to realize that there would be criticism that came, just like Mr. Ryan has experienced. Do you think that might explain why we haven't gotten a plan submitted to Congress?

Mr. BLUM. I think the President since he took office has said that reducing Medicare costs, overall health care costs, is one of our greatest challenges in the context of overall health care reform. The President submitted a budget in 2009 that will reduce—that would have reduced Medicare spending by $300 billion. Many of those provisions were adopted in the Affordable Care Act.

Mr. GOWDY. What about 2010?

Mr. BLUM. He continues to suggest new ideas, for example, to reduce waste, fraud and abuse. This April he proposed in the context of the overall debt ceiling reductions for a $400 billion additional reduction for both Medicare and Medicaid, and he continues to suggest new ideas in the context of the overall debt ceiling discussions.

Mr. GOWDY. Mr. Blum, I'm going to ask you again, do you take the position that ObamaCare meets the statutory requirements of the trigger legislation?

Mr. BLUM. My position is that due to the savings provisions that were included in the Affordable Care Act, Medicare solvency has been increased by 8 years. The 45 percent trigger will be met by 2013, in 2 years' time, through at least 2020. What I think is true is that the Affordable Care Act will reduce Medicare spending, will improve Medicare solvency. We have more work to do, but by 2013 the 45 percent trigger will be met.

Mr. GOWDY. So that's a long way to say you do take the position that introducing or passing ObamaCare absolves you from having to meet any other trigger requirements?

Mr. BLUM. I think the President has been clear that we have much more work to do to ensure Medicare solvency.

Mr. GOWDY. Well, I'm wondering if part of that work might be complying with the law and submitting a plan to Congress as is required when you get warnings from the trustees?

Mr. BLUM. I believe that the first year that the warning was issued was in 2006, possibly 2006 or 2006–2007. The first year the President took office, he submitted a proposal to the Congress to reduce Medicare spending by $300 billion. The Affordable Care Act took many of those proposals to reduce spending by $500 billion. We are working very hard to implement those provisions. We have extended—those provisions have extended solvency by 8 years to the Part A trust fund by 2013. The trigger has been met through at least 2020. So I believe we are—we have complied with the intent to the 45 percent trigger.

Mr. GOWDY. Well, I'm way out of time, so I will recognize the gentleman from Illinois Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

Mr. Blum, I'm aware that we are searching for alternatives to reform Medicare. The Ryan plan is one such scenario, but I'm not in favor of merely shifting beneficiaries from one Federal plan to another. The Congressional Budget Office said the following about the Ryan plan, and I'm actually quoting: As the eligibility age for Medicare rose from 65 to 67, some people who were 65 or 66 years old or were approaching those ages would turn to other programs for health care and income support. For example, more people might apply for disability benefits under the Disability Insurance Program or under the Supplemental Security Income Program. Most people on disability insurance receive Medicare benefits after a 24-month waiting period, and Supplemental Security Income beneficiaries receive Medicaid benefits immediately under current law. Most people might also apply for the Supplemental Nutrition Assistance Program or other welfare programs.

Is it reasonable to believe that under the Ryan plan, seniors will be forced to rely on other public health programs or simply not obtain those services at all?

Mr. BLUM. My reading of the Congressional Budget Office analysis of Chairman Ryan's plan is that it would shift additional cost onto Medicare beneficiaries; that the way the program is structured, to my understanding, is that it sets a premium support system that grows over time by an amount less than the overall projected trend rate in health care costs, and, as a result, that shifts costs onto Medicare beneficiaries relative to what they would have paid without the proposal.

Mr. DAVIS. And it's also my understanding that the nonpartisan Congressional Budget Office found that a typical beneficiary would spend more for health care under the proposal than under CBO's long-term scenarios for several reasons. First, private plans would cost more than traditional Medicare because of the net effect of differences in payment rate for providers, administrative costs and utilization of health care services as described above. Second, the government's contribution would grow more slowly than health costs, leaving beneficiaries with more to pay. Is that your understanding of this scenario?

Mr. BLUM. Correct. I think if you look at the history of private plans operating within the Medicare program, they have historically not been less expensive than the traditional fee-for-service Medicare program. Today we spend about 108 percent on average more for private plans for those beneficiaries who join a private plan relative to the traditional fee-for-service program. Now, those payment differentials are coming down. But I think one of the points from the Congressional Budget Office is that they estimate that the cost to administer health care coverage through private plans relative to the fee-for-service program would be more expensive, and that's one of the reasons why beneficiaries would be projected to pay more than they would without the new program put into place.

Mr. DAVIS. In your analysis, would you suggest that the Affordable Care Act actually helps to reduce the cost of Medicare?

Mr. BLUM. The Affordable Care Act reduces Medicare beneficiaries' out-of-pocket costs in a number of ways. One is that it constrains cost growth. So to the effect that the program pays less,

beneficiaries pay less through lower copayments and lower premiums.

The Affordable Care Act also phases out the so-called Part D doughnut hole. This year beneficiaries will save hundreds of dollars in out-of-pocket costs for brand-name prescription drugs. And also that the program provides free cost sharing for certain preventive benefits.

So, yes, the Affordable Care Act will lower out-of-pocket costs relative to previous law.

Mr. DAVIS. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Mr. GOWDY. I thank the gentleman from Illinois.

The chair will now recognize the gentleman from Tennessee Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman. And thank you, Mr. Blum, for appearing today.

Just in continuation of the conversation we were just having, you were talking about lowering health care costs under the ObamaCare plan for Medicare recipients. Does the plan take into account the fact that there are 10,000 new Medicare recipients entering the Medicare pool daily? Does it take into account the fact that the average life expectancy now versus 1965 has grown by about 10 years? I believe the average life expectancy in 1965 was 68 for a male, and it's much higher now, thankfully.

The CBO says that it will be insolvent by 2024. With all those considerations, is that all covered in the Affordable Health Care Act, and is that going to be taken care of in terms of still being able to lower costs despite this huge influx and the CBO report that Medicare is going to be insolvent?

Mr. BLUM. Well, the trustees report that I cited during my opening statement projected that Medicare Trust Fund solvency will be increased by 8 years, that the 45 percent trigger will be met by 2013, per capita spending will be constrained over the next 10 years relative to the previous 10 years. Those projections also include the fact that beneficiaries live longer, the fact that more beneficiaries due to the baby-boom generation will be added to the program. So the figures that I cited take into account the demographic changes that are projected to happen to the Medicare program.

Mr. DESJARLAIS. And as a practicing physician who has taken care of many Medicare patients, do you believe that we can reduce the cost the way you speak here and maintain quality of care?

Mr. BLUM. I think one of the greatest challenges and also opportunities that is contained within the Affordable Care Act is the opportunities to use payment reform to change how we think about paying for care, to shift to paying for value from paying for volume. The Affordable Care Act includes many provisions to make our health care system safer, more focused on outcomes; for example, focusing on hospital readmissions.

So the spirit of the Affordable Care Act is to constrain cost growth in part by lowering payment updates to providers, but also to fundamentally change how we think about paying for care, to focus on the value, to focus on the outcome rather than just the volume of services.

Mr. DESJARLAIS. What is it going to do with the SGR, because that's a looming issue that concerns both the recipients of health care, because seniors are already having difficulty finding providers, and providers seem to be exiting the Medicare plan because of the cost cuts? Right now we have anywhere from a 21 to a 28 percent cut. Does your plan include a 30 percent pay cut to providers?

Mr. BLUM. Congressman, you are correct, according to our current projections, that if Congress does not extend the so-called SGR extensions, that CMS will that have to reduce physician payments by 30 percent. We are very concerned about this projected payment reduction. And while we don't see any disruptions to access the physician services across the country right now, we are concerned that physician access could be compromised if this cut were to take into effect. The President has called for a permanent fix to the SGR, one that's also fiscally responsible.

Mr. DESJARLAIS. How are we going to pay for that? I mean, what are we going to tell our seniors right now, don't worry, we're going to cut physicians' pay by another 30 percent, when essentially there hasn't been a pay increase for a decade now despite rising health care costs, overhead costs, and physicians are going to be paid probably 50 percent less than they were a decade ago? Do you really think that's going to fly? Can you tell our seniors with any confidence that doctors are going to be there for them, and what does the Obama administration have as a solution for this?

Mr. BLUM. I can't speak for the Congress, but the President this year in his 2012 budget submission proposed a 2-year extension that was fully paid for through payment reduction, through improvements to how we think about waste, fraud and abuse within the Medicare program. But the President has also called for a permanent solution, but one that's also done in a fiscally responsible way.

Mr. DESJARLAIS. So we're going to kick the can down the road?

Mr. BLUM. I think what the President has said is that we need to find a permanent solution working with the Congress. His budget submission this year included a 2-year extension, but his policy—very strong policy preference is for a permanent fix to the SGR.

Mr. DESJARLAIS. Okay. So we'll worry about it when I get there is basically what I'm hearing.

Let's talk about IPAB quickly, because we're running out of time. That's another area that I think maybe even the administration recommend is flawed. We have an Independent Payment Advisory Board that is basically tasked with rationing health care even though they're saying that they're not allowed to ration it, but they are tasked with cutting Medicare. And I find it interesting that the Ryan plan has been accused of ending Medicare as we know it when in reality ObamaCare within the next 2 years is going to start making drastic cuts to payments to Medicare recipients and providers, and I see a recipe for disaster.

Mr. GOWDY. Mr. Blum, the gentleman's time is expired, but I don't want to prevent you from answering. I would just ask you to answer in light of the fact that the gentleman's time has expired.

Mr. BLUM. Thank you.

I think that the overall goal that we have, I think all of us have, is to ensure that cost growth remains lower than in the past. And I think one of the reasons that Congress did include the IPAB provision was to create a check on overall per capita growth.

In my opinion, we need to look at a whole host of different solvency measures. The 45 percent trigger looks at the mix of financing, but it doesn't necessarily look at the overall cost growth. And I think that the Affordable Care Act's goal, CMS's goal, is to ensure that we have lower cost growth than the past to ensure the program remains affordable both for taxpayers and for beneficiaries.

Mr. GOWDY. I thank the gentleman from Tennessee.

The chair would now recognize the gentleman from Maryland, the ranking member of the full committee Mr. Cummings.

Mr. CUMMINGS. Mr. Chairman, I see that we are about to start voting on the floor, so I will be brief.

Let me ask you, Mr. Blum, one of the things about the Affordable Care Act, and it's something that my seniors applaud, is the whole idea of wellness. I cannot tell you the number of people that I see in my district who call me and say, Cummings, you know, I found out I had prostate cancer, and they said it was too late, too late. In other words, they didn't get the exam earlier. Or they found out they have some other disease that is going to cost a lot, end-of-life care. And I was wondering, as you all see it, the Affordable Care Act had provisions to try to address some of the costs by keeping people well; is that correct?

Mr. BLUM. The Affordable Care Act included several provisions, one of which was for the first time to add the opportunity for Medicare beneficiaries to have an annual wellness visit, a conversation with their physician to ensure that they're complying with recommended preventive tests; to check medications to ensure that the mix of medications is correct. Almost 1 million Medicare beneficiaries to date has taken advantage of that new wellness visit.

The Affordable Care Act also included provisions to lower barriers for beneficiaries to take advantage of preventative benefits by waiving the cost sharing for certain preventative benefits. And I think that in our opinion at CMS is that we need to keep our beneficiaries healthier for longer periods of time. That's the right thing to do for beneficiaries, but it's the right thing to do for overall Medicare costs. We know that when beneficiaries come onto the program without coverage, they cost more than beneficiaries who have coverage turning age 65. So that gives us evidence that when we focus on the health, we focus on the well-being, we ensure that beneficiaries receive care when they need it, that the overall costs are lower.

Mr. CUMMINGS. If you will recall, when I did my opening statement, I talked about a question that concerns me, and I'm sure many others. If you got a senior who is 65 years old with no—who has diabetes and who has heart disease, I asked the question, who is going to insure them? And I'm sure you all have tried to figure this out because you realize that there is a Republican plan. And so under that plan have you figured out who is going to insure those folks, because I've got a lot of folks in similar situations in my district.

Mr. BLUM. Well, the plan as I understand it, Chairman Ryan's plan, would take effect in 2022. I think it's hard to predict which insurance companies would come into a market in more than 10 years' time. But I think the keys are to have very strong risk-adjustment mechanisms to ensure that plans have very strong incentives to take those that have chronic illness, the chronic sick. The history of the private plan system within the Medicare program to date has been that when we don't account for the high cost that beneficiaries with diabetes or other chronic conditions have, that plans figure out ways not to care for them.

Mr. CUMMINGS. You talked about waste, fraud and abuse, and that's been certainly a subject that has come before our full committee quite a bit and is something that we are tasked with addressing. And, you know, do you all see a lot of waste, fraud and abuse in the Medicare system, and do you—you know, those are words that we hear over and over again, I mean every year. I've been hearing it for the last 15 years since I've been here, waste, fraud and abuse; waste, fraud and abuse. The question is, do we have a plan to truly attack that?

Mr. BLUM. I think in 2009 there was an historic coming together of both CMS and the law enforcement agencies, Department of Justice, of trying to do more than what was done in the past to reduce true fraud in the program. One thing that was put into place is Operation HEAT, which targets both law enforcement resources and also analytic resources to the hotspots of the country for Medicare fraud. We know that fraud tends to be in certain parts of the country, then it moves when law enforcement moves in. So the key really is to follow the hotspots and ensure that the fraudsters don't get ahead of law enforcement.

Second is that we are using data analytics in novel new ways to both find waste, fraud and abuse, but also to predict where waste, fraud and abuse could be happening.

And the third area is that we need to make sure that our payment policies are correct, they don't overinflate to create incentives for fraudsters or bad actors to come into the program. One example is that we have reduced prices paid for certain durable medical equipment. That's an area that we have a lot of fraud in the program by 32 percent. So if we target the hotspots, we use data wisely, we also set our payment policies right, that we will make a serious dent in waste, fraud and abuse.

Mr. CUMMINGS. Thank you. I yield back.

Mr. GOWDY. I thank the gentleman from Maryland.

Mr. Blum, and to my colleagues Mr. Clay, Ms. Holmes Norton, Dr. Gosar, we've got about 10 minutes left to vote. It looks like it may be a series of some length. What I can promise you is we will be back here as quickly as we can get back here.

Mr. BLUM. I'm happy to stay.

Mr. GOWDY. Well, we all apologize, but we can't control when votes are called, and sometimes can't control how long they last. But I'll make you the commitment we will get back here. I'm not going to tell you we're going to run, but we'll walk briskly to get back here.

Mr. BLUM. It's too hot to run.

Mr. GOWDY. And we'll be in recess until such time as we can come back. And again, we apologize for any inconvenience.

Mr. BLUM. Thank you very much.

[Recess.]

Mr. GOWDY. Mr. Blum, and to all our guests, again, we apologize for any inconvenience for what was an especially long vote series.

The chair will now recognize the vice chairman of the subcommittee Dr. Gosar, the gentleman from Arizona.

Mr. GOSAR. Thank you, Chair.

Mr. Blum, do you agree—or do the current law projections include a 30 percent cut in the provider payment rate schedule to occur next year?

Mr. BLUM. The trustees reports——

Mr. GOSAR. How about yes or no?

Mr. BLUM. No, it does not. The trustees report projects current law, and the current law would have a 30 percent cut in 2012 absent congressional legislation.

Mr. GOSAR. Okay. The chief actuary at CMS says that many of the providers will find it difficult to remain in Medicare if provider payments are cut dramatically. I find that in Arizona already. So if we are making further cuts, we are not going to see a lot of providers or access to care, right?

Mr. BLUM. I think what the chief actuary has said is that it is possible that Congress may repeal some of the savings provisions that are——

Mr. GOSAR. May repeal?

Mr. BLUM. Correct.

Mr. GOSAR. So that's a maybe, not a definitive?

Mr. BLUM. What the trustees report has projected current law, and current law has productivity of payment adjustments for hospitals and other health care providers really to incent more efficiency. And so the actuaries have projected an alternative scenario for future costs if Congress were to repeal some of the changes and also that if Congress were to provide a permanent fix to the SGR.

Mr. GOSAR. Well, we didn't include the SGR into that fix, did we?

Mr. BLUM. Which fix, I'm sorry?

Mr. GOSAR. I mean, the health care bill did not take in the SGR fix.

Mr. BLUM. Current law provides that in January 1, 2012, that physician payments would be reduced by 30 percent or so.

Mr. GOSAR. And you actually think that's going to go through?

Mr. BLUM. The President has called for a permanent fix to the SGR when it is done in a fiscally responsible way. The administration is hopeful that the Congress will address the long-term SGR, but the President has said that it should be done in a kind of fiscally responsible way. His 2012 budget submission provided a paid-for 2-year extension, but he has also said his very strong commitment for a permanent fix to the SGR.

Mr. GOSAR. Well, I understand the commitment and trying to perform the fix. Have you actually been on the ground, because, you know, physicians are chasing their tail, so a cut is improbable, just because it just doesn't work that way in a physician's office.

Mr. BLUM. I have traveled throughout the country over my time at CMS, and what I hear is tremendous frustration from physicians

about sort of the current uncertainty to what physician payments will be in the future. The good news is that so far we're not seeing any access issues for beneficiaries nationwide, but if the 30 percent cut were to go into effect, that we would have to be very worried about access to physician services.

Mr. GOSAR. But we're already starting to see that. I'm from rural America, from rural Arizona, and we're starting to see it already. Because, once again, we're just chasing our tail because we're not getting paid, and we're hopefully getting down the road so that we get some compensation. And so there's no efficiency in that model whatsoever, and there's no efficiency in some of the clinics as well when we're talking about paying encounter fees just so that we have a single WIC mom coming 5 different weeks for 1 visit not even seeing a physician. That's not called efficiency in my book.

Mr. BLUM. I think the Affordable Care Act provides CMS new tools and new payment authorities. And I think one of our challenges, but also our opportunities, is to change how we pay for physician services and other services to promote greater care coordination, to promote more efficiency in payments, to reward outcomes rather than just volume of services.

So one of the highest priorities that we have at CMS is to build the next generation of payment systems to ensure more accountability, greater quality outcomes. But I agree with you, Congressman, we have to address the 30 percent shortfall that's scheduled to take effect.

Mr. GOSAR. I'm going to go back to this. Your testimony assumes, at least the numbers you're reporting to us assumes, that there's a physician 30 percent cut, right?

Mr. BLUM. The actuary's report this year assumes that the 30 percent cut will go into effect. That assumes current law. What the President has called for is a fiscally responsible permanent fix to the SGR. He has proposed a 2-year extension that's fully offset by other changes to the Medicare and Medicaid programs.

So we agree that we need to find a permanent solution to our current physician shortfall, but at the same time we need to make sure that the Medicare program remains strong for future generations. Part of that strategy is to ensure that we build a next generation of payment systems to ensure the health care is more efficient, that it's more accountable, that it rewards care coordination, and through payment improvements, through delivery improvements, we can save tremendous amounts of money.

Mr. GOSAR. Don't you feel—just real quick, Chairman—don't you feel that not mentioning this 30 percent cut is misleading?

Mr. BLUM. It depends how the 30 percent cut is implemented, and I can't speak to how Congress will change. But it can be done in a budget-neutral manner, it can be done in a nonbudget-neutral manner.

What I can speak to is the projections; to the trustees report that has projected additional Medicare solvency; the Part A trust fund, that doesn't include physician services. No matter what the SGR change is, the Part A trust fund will be solvent for 8 more years.

Mr. GOSAR. Well, I have to interrupt because that's a contingency on having more jobs in this country, and if you last looked, that didn't work. And I know that the hospitals bought into making—

agreed to certain cuts, and now those cuts are even greater. All I got to tell you is that the hospitals back home in rural America are saying, no way. So I think you need to redo your math. Thank you.

Mr. GOWDY. I thank the gentleman from Arizona.

The chair would now recognize the gentlelady from the District of Columbia Ms. Holmes Norton.

Ms. NORTON. Thank you very much, Mr. Chairman. Actually I thank you for this hearing because I think it allows us to get some information on the record.

Many would say that the present majority got here or was able to take over the House by the way they characterized what I think many would regard as the only savings, substantial savings, in Medicare in a long time and with virtual demagoguery about the Medicare Advantage program. Now, a quarter of our seniors get Medicare Advantage, but the last time I heard, all seniors, like all men and women, are created equal, except that we spend $14 billion, I believe the figure was, more on those who enrolled in this private beneficiary plan and then got, shall we call it, premium support from the Congress, except that premium was the bulk of what was $14 billion. Now, if they had stayed in traditional Medicare, of course, the cost would have been less, $14 billion less, to be exact. So isn't it the case that the Affordable Care Act, by correcting this overpayment, in fact, saved Medicare funds for the first time that anyone has been able to do so in any large amount of funds?

Mr. BLUM. The Affordable Care Act phases down the higher payments that are made to Medicare to vanish plans down to a level on average that will be closer to the traditional fee-for-service program.

Ms. NORTON. So you could still get it?

Mr. BLUM. Correct.

Ms. NORTON. But you couldn't get all those extras that sent you way above what other Medicare patients were getting, seniors were getting?

Mr. BLUM. Sure. CMS began to phase in those payment reductions last year. They will continue over the next several years. Contrary to predictions, more Medicare beneficiaries are going into the Medicare Advantage program. We expect that it will continue to grow over the next several years. So while we are phasing down payments, we are also increasing our oversight of the plans. We are——

Ms. NORTON. So people continue in their plans, or in that—those who prefer private plans continued in it even though they didn't get this overpayment?

Mr. BLUM. And more are signing up every day.

Ms. NORTON. Let me ask you about another one of these concerns. When Part D was passed, we bemoan the fact it wasn't paid for. It is, in fact, the case that the Affordable Care Act was paid for; is that not the case?

Mr. BLUM. The Affordable Care Act included $500 billion in cuts to the Medicare program. While there were some savings provisions that were included within the Medicare Modernization Act of 2003, that is correct, that the Part D benefit was not paid for.

Ms. NORTON. That was a lot not to be paid for. But as we know, the trustees—I'm sorry. Yes, the trustees have to let us know when the general funds are being tapped to pay for Part D. Now, the figures I have show that 82 percent of the financing of Part D comes from general revenues and only 10 percent from beneficiary premiums. States make up 7 percent of the financing, according to the figures I have. The Medicare trigger denoting you've reached that 45 percent was almost immediately pulled.

Do you believe that lowering the Medicare D prescription drug spending would reduce the chances of this, of triggering the general services, the general revenue obligation?

Mr. BLUM. Sure. The 45 percent trigger is triggered when nondedicated revenues are greater than 45 percent. The Part D benefit in its current structure is financed. Roughly 75 percent in beneficiaries pay—beneficiaries who are not——

Ms. NORTON. Could I ask you now, in the Affordable Care Act we closed the doughnut hole over time. Now, how do we pay for that? We say that was paid for.

Mr. BLUM. The Part D doughnut hole was estimated to be about $16 to $20 billion of costs. That could be wrong. I'll have to get back to you with an accurate figure. But the changes to close the doughnut hole were fully offset by other savings provisions within the Affordable Care Act.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. GOWDY. I thank the gentlelady from the District of Columbia.

The chair would now recognize the gentleman from Vermont Mr. Welch.

I'm sorry. Mr. Murphy. I apologize.

Mr. MURPHY. Thank you very much, Mr. Chairman. Vermont is a beautiful place. So is Connecticut.

Mr. GOWDY. My apologies.

Mr. MURPHY. Mr. Blum, thank you very much for appearing today. I want to just maybe extend the conversation that Ms. Norton was having with you regarding what has happened to Medicare Advantage. She talked about the fact that more, not less, people are signing up since the Affordable Care Act has been passed. Can you talk a little bit about premiums for seniors as it relates to premium increases prior to the subsidies being taken away?

Mr. BLUM. Sure. Currently that the average premium for those beneficiaries who are in the program are 6 to 7 percent lower than they were last year. So we're seeing an average decline of premiums for beneficiaries that are still in the program. Average benefits have stayed the same, and more Medicare beneficiaries are signing up for the program relative to overall growth to the program overall. So payments are coming down, more beneficiaries are going into the program relative to last year, and average premiums are declining.

Mr. MURPHY. Do you have a guess as to why premiums are coming down?

Mr. BLUM. Well, I think that when the program—when CMS is a tougher negotiator—last year we denied plan bids for the first time with new authorities that were provided to the Secretary to oversee the program. We are actively managing the program. We

are being much more stronger stewards of the program. And I think the lessons that I've taken is that when we have enhanced our oversight, promoted competition, simplified beneficiary choices, held plans to the standards that are consistent with our goals and values, competition increases, premiums are lower, and beneficiaries are more satisfied and join plans.

The Affordable Care Act provides a tremendous new tool to our oversight of the program. For the first time starting in 2012, we'll be able to provide bonus payments to those plans that provide the greatest quality outcomes, the greatest performance. So I think we have more tools than we have had in the past, but CMS has a stronger commitment to oversee the program, and when that happens, we get lower costs for taxpayers, lower premiums for beneficiaries, and stronger take-up in the program.

Mr. MURPHY. Well, I think that's really important information to have because—and I sat on the Energy and Commerce Committee and listened for a year and a half to opponents of health care reform tell us two things, that if we were to remove the subsidies, the 13 to 15 percent subsidies above what traditional Medicare costs, that plans would close up shop. And seniors would no longer be able to have offered to them Medicare Advantage plans, and/or costs would skyrocket. And exactly the opposite has happened. Since the Affordable Care Act has been passed more people are signing up for Medicare Advantage, and it is costing people less, which is frankly something you don't see almost anywhere else in the health care system, people's premiums actually declining.

And I think that's significant, because as we are sitting here trying to assess how best to create benchmarks for our health care system for the Medicare program, the benchmark that we're looking at today is one regarding the percentage of general revenues that go into the program. But an equally important benchmark is how much individual beneficiaries are paying out of their pocket. And the fact that the Affordable Care Act has meant that Medicare Advantage beneficiaries are paying less, that Part D beneficiaries are paying less, that Medicare beneficiaries who are going to have to pay for preventative care are paying less has just as much to do with whether or not we're achieving the ultimate goals of the program as does a question of how much general revenues are being put into the program.

I think that's incredibly important as we talk about the current plan before us by the Republicans to radically change the way that Medicare is structured, because what we know is this, and CBO tells us, that the average beneficiary is going to go from paying about 20 to 30 percent of health care costs to somewhere in the neighborhood of 65 to 70 percent; that they are going to see their out-of-pocket expenses under the Ryan Medicare privatization plan be tripled over a 20-year window; 65- and 66-year-olds would probably completely lose the ability to receive Medicare. Now, that means something to each individual beneficiary, but it also means something to the Federal Government. It also means that those 65- and 66-year-olds leach out somewhere else into the system, and a lot of the costs that are borne by the beneficiary end up resulting in people not receiving preventative care getting sicker and costing us less later on.

So I would like to see us have benchmarks, but I think one of the benchmarks should also be how much money is coming out of the pocket of each individual beneficiary. And I think the Republican plan before us on this radical rewrite of Medicare will make tracking those expenses even more important.

I thank the chair for the time, and I yield back.

Mr. GOWDY. I thank the gentleman from Connecticut. And I apologize again for moving him without his consent.

Mr. Blum, on behalf of all of us, thank you for sharing with us your perspective and for indulging us as we went to vote.

We will—I'm not even going to leave. I'm going to ask the second panel to come up, and if any of my colleagues need a break, they're welcome to take it, otherwise we'll go right into the second panel.

We want to welcome our second panel. I will introduce you from my left to right, your right to left. Dr. Charles Blahous III, is public trustee of Medicare and Social Security. Dr. Joseph Antos—and if I mispronounce anyone's name, I apologize in advance—is the Wilson H. Taylor scholar in health care and retirement policy. Mr. James Capretta is a fellow with the Ethics and Public Policy Center. And Dr. Paul Van de Water is a senior fellow with the Center on Budget and Policy Priorities.

Pursuant to committee rules I will ask all four of our witnesses if they would please rise so I can administer the oath.

[Witnesses sworn.]

Mr. GOWDY. May the record reflect all the witnesses answered in the affirmative.

Mr. Blahous, we will recognize you for your 5-minute opening, and then we will go from your right to left, my left to right.

STATEMENTS OF CHARLES P. BLAHOUS III, PUBLIC TRUSTEE OF SOCIAL SECURITY AND MEDICARE; JOSEPH ANTOS, WILSON H. TAYLOR SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE; JAMES C. CAPRETTA, FELLOW, ETHICS AND PUBLIC POLICY CENTER; AND PAUL N. VAN DE WATER, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

STATEMENT OF CHARLES P. BLAHOUS III

Mr. BLAHOUS. Thank you, Mr. Chairman, Mr. Ranking Member. It's an honor to appear before you today to discuss the funding warning in the 2011 trustees report. My written testimony contains some basic background about Medicare financing, and in view of the limited time, I would just like to make a few cursory summary comments in my oral remarks.

First, Medicare has two trust funds. It has a Hospital Insurance Trust Fund, which we call Part A, and it has a Supplementary Medical Insurance Trust Fund. And that's different—that's important to know because financial strains on each side of the program are manifested in different ways. On the Part A side, in the hospital insurance side, we as trustees make projections that are somewhat like the ones we make for Social Security. We project forward future program income, future program expenditures. We make a determination as to whether they're out of balance. We make a determination as to whether or not there's a date by which

the trust fund will be exhausted. And naturally there's great public and press interest each year in the trustees' annual projections for a date of depletion of the HI Trust Fund.

On the SMI side things operate somewhat differently. On that side general revenues, enrollee premiums are reestablished each year to match expected costs. So that side of the program doesn't go insolvent. When there are financial strains there, they are manifested in rising premiums, rising general revenue pressures.

Now, if you look at Medicare as a whole, it's bringing in income from a lot of different sources. Some of these sources are dedicated revenue sources like payroll taxes, benefit taxes, premiums, State transfers. And some of the revenue sources are simply general revenue transfers from the remainder of the Federal budget without a dedicated financing source. And the distinction between these different revenue sources is important for the government's ability to finance Medicare.

Whenever you increase revenues from a dedicated financing source, like payroll taxes or benefit taxes, you not only improve the status of the Medicare Trust Funds, but you improve the government's general ability to finance Medicare because you're also improving the unified budget balance. But if you increase general revenues contributions to Medicare, you can increase the balance of the Medicare Trust Funds, but that's at the expense of the general fund. It doesn't actually improve the government's net ability to finance Medicare. So it's important to keep an eye on the size of those general revenue obligations.

Now, under our projections, the parts of Medicare that are funded predominantly by general revenues are going to grow substantially in the years to come. SMI was about 1.9 percent of GDP in 2010. We show that rising pretty sharply to about 3.4 percent of GDP by 2035, continuing to rise afterwards. And this is going to mean increased pressures on general revenues. We show general revenue requirements of 1.5 percent of GDP this year gradually rising to over 3 percent of GDP by 2085.

Now, as you noted in your opening statement, the 2003 MMA directs the trustees to determine whether there is excess general revenue Medicare funding, and that means more than 45 percent of total Medicare outlays funded from general revenues in any of the first 7 years of our projection period. And we did make such a finding for this fiscal year, 2011. This is the sixth consecutive Medicare Trustees Report that has made such a finding. Whenever that's done in two consecutive reports, we must issue a funding warning, as we did this year. Under our latest projections we would be over 45 percent in fiscal years 2011 and 2012. We would need revenue increases of about $25 billion, benefit reductions of about $46 billion, or some combination thereof, to get that ratio down below 45 percent for both 2011 and 2012.

Now, under current law assumptions, which has been noted here assumes that we allow a 29 percent reduction in physician payments to go into effect next year, this ratio would drop below 45 percent in years 2013 through 2021 and then rise afterwards. By 2034, the ratio would hit 54 percent and stay at roughly that level through the remainder of the 75-year period.

In sum, Mr. Chairman, the Medicare funding warning eliminates a part rather than the whole of the financing challenge facing Medicare. It basically represents a facet of the financing challenge that is in a sense complementary to the projections that we make for the solvency of the Part A trust fund. It looks at other aspects of program financing that the HI solvency calculation doesn't deal with.

This year we found that the gap between Medicare's dedicated revenues and expenditures will exceed 45 percent of outlays in each of this year and next under current law, thereby triggering the Medicare funding warning pursuant to the MMA.

Thank you, Mr. Chairman.

Mr. GOWDY. Thank you, Doctor.

[The prepared statement of Mr. Blahous follows:]

Statement of Charles P. Blahous

Research Fellow, Hoover Institution and Public Trustee for Social Security and Medicare

Before the

Subcommittee on Health Care, District of Columbia, Census and the National Archives,

U.S. House of Representatives Committee on Oversight and Government Reform

July 12, 2011

Thank you, Mr. Chairman, Mr. Ranking Member, and all of the members of the subcommittee. It is an honor to appear before you today to discuss the financial condition of the Medicare program and the issuance of a "Medicare funding warning" in the 2011 Trustees' Report. My testimony will begin with some basic background of Medicare financing before explaining the details of the Trustees' warning.

Medicare Trust Funds and Financing

A primary responsibility of the Medicare Trustees is to report annually, usually each spring, on the current and projected condition of the Medicare Trust Funds. Medicare has two trust funds, the Hospital Insurance (HI) Trust Fund (sometimes known as Part A) and the Supplementary Medical Insurance (SMI) Trust Fund (which includes both Part B, a voluntary enrollment program of physician, outpatient hospital and home health services, and Part D, another voluntary program that provides prescription drug benefits). Medicare also has a Part C, the "Medicare Advantage" program, whose costs are paid from both the HI Part A and SMI Part B Trust Fund accounts. As is the case with Social Security, the HI and SMI Trust Funds contain special-issue Treasury bonds, which earn interest and provide a financing reserve that can be drawn upon whenever incoming dedicated revenues fall short of outgoing expenditures.

The Trustees' projections for the HI (Part A) Trust Fund are somewhat analogous to those made for the Social Security program. For each of these, the majority of program revenues are provided by a payroll tax imposed upon worker wages and self-employment earnings. For Medicare HI, also as with Social Security, the Trustees determine whether there is an aggregate imbalance between projected program income and expenditures, as well as the date (if any) by which Trust Fund assets are projected to be exhausted.

By contrast, the finances of Medicare's SMI Trust Fund operate somewhat differently. Part B and Part D premiums and contributions from general revenues are re-established annually to match expected costs. SMI is thus kept solvent essentially by statutory construction. Financial strains on the SMI side, therefore, are manifested not in a projected actuarial imbalance or a date of trust fund depletion, but in rising requirements of general government revenues and enrollee premiums.

Altogether, Medicare receives income from a variety of sources, some of which are dedicated revenues incoming from sources outside of the federal government. It also receives a significant amount of general revenues, which are in effect a draw on the general government accounts for which there is no dedicated financing source. To the extent that the future solvency of the Medicare Trust Funds depends on general revenues (and interest payments), these represent cost obligations facing the federal government with the important question fully open as to where the financing will come from.

There is naturally a great deal of public and press interest each year in the Trustees' evolving projections for the duration of solvency of the HI (Part A) Trust Fund. This important information, however, represents just one component of overall Medicare financing. Because the other parts of Medicare are kept solvent basically by statutory design, and are simply provided with general government revenues as needed to meet costs, a fuller picture of Medicare financing must account not only for the financial health of the HI Trust Fund but also the extent of reliance upon general revenues to fund Medicare as a whole.

For Medicare HI (Part A), the largest source of income is a 2.9% tax upon wage earnings, nominally split between employer and employee. Starting in 2013, single taxpayers with earnings above $200,000 and married couples over $250,000 will also pay an additional 0.9% tax to the HI Trust Fund. Medicare HI (Part A) also receives income from the taxation of Social Security benefits (up to 85% of such benefits are subject to the income tax, with taxation on 50% dedicated to Social Security and the remaining 35% to Medicare HI).

In Parts B and D, general revenues provide the vast majority of financing (74% of total revenues for Part B, 83% for Part D). Another significant portion of Part B revenues comes from beneficiary premiums. For Part D, another smaller portion of revenues is provided via payments by States, these latter revenues representing a partial payment of foregone drug costs for dual beneficiaries as such costs were transferred from Medicaid to Part D.

Medicare Income Sources, 2010 ($ Billions)

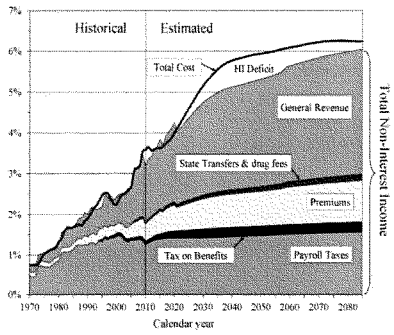
	Part A	Part B	Part D	Total
Payroll taxes	182.0	0.0	0.0	182.0
Taxation of benefits	13.8	0.0	0.0	13.8
Premiums	3.3	52.0	6.5	61.8
Transfers from States	0.0	0.0	4.0	4.0
General revenue	0.1	153.5	51.1	204.7
Interest	13.8	3.1	0.0	16.9

Other	2.7	0.2	0.0	2.9
Total	**215.6**	**208.8**	**61.7**	**486.0**

Total Medicare expenditures in calendar year 2010 were roughly $523 billion, of which roughly $516 billion were benefit payments and the remaining $7 billion administrative expenses.

As Medicare costs are projected to grow over time, one consequence of this growth (particularly within SMI) will be increased pressure on the general federal budget. SMI costs equaled roughly 1.9 percent of GDP in 2010, are projected to rise sharply to 3.4 percent of GDP in 2035, and to continue to rise beyond then. General revenue requirements for SMI are projected to rise from 1.5 percent of GDP in 2011 to 3.1 percent of GDP in 2085, as shown on the graph below. Costs for Medicare as a whole are projected to rise rapidly from 3.6 percent of GDP in 2010 to about 5.6 percent of GDP by 2035, and to increase gradually thereafter to about 6.2 percent of GDP by 2085.

Medicare Costs and Non-interest Income by Source as a % of GDP



An important caveat about these projections should be added. The Trustees' report indicates in several places that actual costs are likely to be higher in practice than shown in that report. The main reason for this has to do with the lack of certainty that current law will be implemented as written. Early next year, for example, physician payments would be reduced under current law by about 29% under an SGR formula that Congress and the Administration have repeatedly overridden in recent years. Also, as members of this subcommittee are well aware, there is a vigorous ongoing debate about whether certain cost-saving provisions of the Affordable Care Act (ACA), most especially the annual downward payment adjustments for multi-factor productivity growth, will be successfully implemented over the long term. We as Trustees are

not in a position to predict how these political economy dynamics will play out, so the main report thus simply projects current law as written. At the same time, the CMS Medicare Actuary publishes an "illustrative alternative scenario" in which the SGR payment adjustments are overridden and the ACA productivity adjustments phased out over 2020-2035. This scenario shows eventual total program costs as being much higher --10.7% of GDP in 2085, rather than the 6.2% shown in the main report. Under this alternative scenario, general revenue pressures would be considerably higher than shown on the preceding graph.

The Medicare Funding Warning

The Medicare Modernization Act (MMA) of 2003 requires that the Board of Trustees determine each year whether the annual difference between program outlays and dedicated revenues exceeds 45 percent of total Medicare outlays in any of the first seven fiscal years of the projection period. When that determination is made in two consecutive reports, a "Medicare funding warning" is triggered. This year's report projects the difference between outlays and dedicated financing revenues to exceed 45 percent of total Medicare outlays during fiscal year 2011, prompting a determination of "excess general revenue Medicare funding" for the sixth consecutive report, triggering another "Medicare funding warning."

The MMA essentially defines "dedicated revenues" as those coming in from HI payroll taxation, Social Security benefit taxation, State transfers, and enrollee premiums (as well as any gifts given to the Trust Funds). In effect, it defines "dedicated revenues" as those that come from a source external to the federal government, as distinct from general revenue obligations that have no such external financing source. These are certainly not the only dedicated revenue sources for Medicare that could theoretically be established, but the law does capture the dedicated revenue sources that now exist within the Medicare system.

The distinction between dedicated revenue sources and others bears significance for the federal government's ability to finance Medicare. To the extent that revenue from a dedicated funding source is increased, it improves both the solvency of the Medicare Trust Fund(s) as well as the government's overall unified budget balance. But to the extent that increased general revenues are provided to Medicare without a dedicated funding source, this improvement comes at the *expense* of the general fund, and without a net improvement in the unified budget balance.

In other words, to the extent that future general revenues are transferred to Medicare, its technical solvency and its authority to pay benefits are increased but there is no corresponding improvement in the government's operative ability to finance the program. Thus, to whatever extent that a "warning" successfully induces changes in law that limit such reliance on general revenue, it also limits the extent to which Medicare financing is provided at the expense of the general government accounts.

The MMA stipulates that whenever the Trustees issue a Medicare funding warning, the President shall submit to Congress during the succeeding year, within 15 days after the submission of his

proposed budget, proposed legislation to respond to the warning. This section of the law includes a sense of Congress that such legislation should be designed to eliminate the "excess general revenue Medicare funding" (i.e., the extent to which general revenue financing exceeds 45 percent of outlays). As a Public Trustee, I am able to present the Trustees' findings with respect to the triggering of the funding warning, but I am not privy to the Administration's deliberations with respect to how to respond to it, nor do I possess expertise on any legal or constitutional issues surrounding these provisions of the MMA.

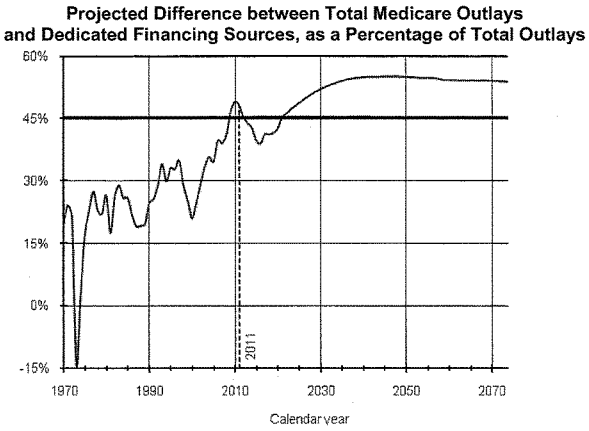
2011 Trustees' Report Findings

The MMA directs the Trustees to determine whether there is "excess general revenue Medicare funding" in any of the first seven years of the projection period. The 2011 Trustees' report presented a finding that the difference between program outlays and dedicated revenues will indeed exceed 45 percent in fiscal year 2011, the first year of the current projection period.

Such a year of "excess" funding within the first seven years has been anticipated in each of the reports from 2006 to 2011 inclusive, meaning that this is the sixth consecutive report to have made such a finding. Whenever the finding is made in two consecutive reports (as first happened in 2007), the Medicare funding warning is triggered as it was this year. President Bush's FY2009 budget submitted in 2008 proposed $556 billion in Medicare savings over the following ten years, specifying that these proposals were responsive to the 2007 warning. These proposals were not acted upon by Congress. In January, 2009, the House of Representatives passed a resolution waiving the requirement of action in response to a Medicare funding warning in the 111th Congress. The current Congress has not waived these requirements.

Under our latest projections, the 45 percent threshold would be exceeded in fiscal years 2011 and 2012. Revenue increases of $25 billion, benefit reductions of $46 billion, or some combination thereof would be required to reduce the ratio below 45 percent for both 2011 and 2012.

Under current-law assumptions (in which provider payments are reduced by roughly 29% in January 2012), the ratio would again drop below 45 percent in years 2013 through 2021, after which the threshold would be exceeded again. By 2034, the ratio would reach 54 percent and would stay at roughly that level throughout the remainder of the 75-year period, as shown on the following graph. If instead we assume the illustrative alternative scenario (in which the physician payment reductions are overridden) then these ratios would be higher, remaining above 45% through 2014 and dropping below the threshold only in 2015-18 before permanently exceeding 45% in 2019 and beyond.



Conclusion

As with the Trustees' annual projections for the duration of solvency of the Medicare HI (Part A) Trust Fund, the Medicare funding warning illuminates a part rather than the whole of the financing challenge facing Medicare. It illuminates a side of Medicare financing that is generally complementary to the Trustees' widely-circulated projection for the HI insolvency date. Whereas the HI Fund solvency projection illuminates program finances from a narrow Trust Fund perspective, and focuses on Medicare's Part A, the Medicare "funding warning" alternatively takes a broader budget perspective and primarily illuminates the financial condition of the Supplementary Medical Insurance program (Parts B and D). In short it represents a complementary facet of the overall Medicare financing picture.

The Trustees find that the gap between Medicare's dedicated revenues and expenditures will exceed 45% of outlays in each of 2011 and 2012 under current law, thereby triggering the "Medicare funding warning" pursuant to the Medicare Modernization Act.

Mr. GOWDY. Mr. Antos.

STATEMENT OF JOSEPH ANTOS

Mr. ANTOS. Thank you, Mr. Chairman. Thank you, ranking member.

The trigger mechanism known as the Medicare funding warning is designed to reflect the combined financial condition of all parts of the Medicare program. It is a complete indicator of everything that's going on with Medicare financing, but it is an important measure. It was intended to call attention to imbalances between Medicare spending and revenue specifically dedicated to fund the program.

The first funding warning was declared by the trustees in 2007 and has been declared by the trustees every year since then. President Bush responded in 2008, his only opportunity to respond. President Obama has not.

I want to emphasize two points. First, for a given level of Medicare spending, the trigger directly addresses how much workers should pay for benefits for seniors. This is a difficult question that we as a society must answer. One can disagree about whether 45 percent is the right level, but that does not invalidate its use.

Second, the Medicare trigger doesn't have teeth. As a result, the trigger has not directly led to legislation to slow the program's cost growth. Nonetheless, the trigger, like the trustees report itself, has raised attention to the fiscal crisis facing Medicare. And I might add the trustees report has been equally unsuccessful in motivating a great deal of policy response to a program that is in crisis, and the crisis is real.

Despite White House claims that the new health reform law keeps Medicare strong and solvent, the Affordable Care Act only modestly improved the program's fiscal outlook. According to the trustees, spending from the HI Trust Fund has exceeded revenue since 2008, and trust fund assets will be exhausted in 2024. SMI funding, that's Part B and Part D—spending, rather, is projected to moderate somewhat from past trends, but the drain on the Treasury remains extremely high. In fact, those estimates are optimistic. They incorporate net Medicare savings from the Affordable Care Act of $575 billion through 2019 and, of course, much more beyond that, primarily through reductions and payments to providers. These are reductions that the Medicare's chief actuary considers unrealistic. The estimates also assume that the Medicare payments to physicians will be cut an unprecedented 30 percent in January 2012. Neither assumption is plausible. Even the trustees state that, "the actual future costs for Medicare are likely to exceed those shown by the current law projections."

In fact, the actuary's office put out a supplementary report to the trustees report, and that report estimates much higher levels of Medicare spending, assuming that Congress rescinds the physician payment cut and rescinds partially the other Affordable Care Act reductions after 2021. They're not assuming that all of those cuts go way, they're assuming that some of them are moderated. According to that analysis, total Medicare spending will be 8 percent higher than the official estimate in 2020, and 14 percent higher in 2030, with spending growth continuing to accelerate beyond that

point. That translates into trillions of dollars of additional general tax revenue that will be needed by Medicare over the next 75 years unless responsible policies are adopted to reduce program costs.

As we've seen, the President and Congress can ignore a Medicare trigger with impunity. That's business as usual in Washington. But neither the President nor Congress actually need the trigger to advance reasonable policy, and that's the point. The President sends a budget to Congress every year. That budget should contain provisions that set Medicare on a sustainable fiscal path not just for a year or two, but more permanently.

Congress also doesn't have to wait for the President to act. The importance of this issue cannot be overstated. Decisions about Medicare financing, whether by conscious policy or by default, will determine the fate of a program that millions of seniors depend on. Those decisions will also shape the limits on Federal support for societies of their priorities.

Rapid growth in Medicare spending is a major contributor to the Nation's debt crisis. Failure to adopt structural reforms to promote greater efficiencies in delivering health care and higher values for our Medicare dollar will be disastrous. The Medicare trigger could be a tool to encourage policymakers to do what they must do, but only if it's taken seriously.

Mr. GOWDY. Thank you, sir.

[The prepared statement of Mr. Antos follows:]

Thank you, Chairman Gowdy, Ranking Member Davis, and members of the Subcommittee for the opportunity to speak today on Medicare's financial status and the need for a policy response to the funding warning issued by Medicare's Trustees in their most recent report.

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

Because of Medicare's complicated structure, it can be difficult to ascertain fully the program's financial status. The date at which the Hospital Insurance (HI, or Part A) trust fund is exhausted is one easily-understood indicator but it focuses on only a portion of Medicare that accounts for less than half of program spending. Congress established a trigger mechanism known as the Medicare funding warning that reflects the combined financial condition of all parts of the program. It was intended to call attention to imbalances between Medicare spending and revenue specifically dedicated to fund the program. In the event of a funding warning, the President is required to present legislative proposals to Congress that would reduce program spending or increase program revenue (or both).

A Medicare funding warning has been declared by the Trustees every year since 2007. President George W. Bush responded by sending a proposal to Congress on February 15, 2008, but Congress failed to act on it.[1] In each of his first three years in office, President Barak Obama has failed to respond to the funding warning.

It is essential that the president heed the clear evidence presented by his board of Trustees that Medicare's ability to finance the promises made to America's seniors is in jeopardy. It is equally essential that Congress act to shore up Medicare's finances, whether or not the president presents his own plan.

Measuring Medicare's Fiscal Status

There is no single number that adequately describes Medicare's fiscal status, and every measure presented in the annual Trustees report depends critically on assumptions about the health system's response over 75 years to federal policy and other changes in the program's environment. The most-widely cited indicator is the insolvency date for the HI trust fund, but that reflects only a part of Medicare's operations.

The HI trust fund can become insolvent because it is financed mainly through payroll tax contributions which are projected to grow more slowly than HI outlays. The Supplementary Medical Insurance (SMI) trust fund, which accounts for financial transactions under Part B for outpatient services and under Part D for prescription drugs, was deliberately designed so that it can never run out of money. Beneficiary premiums account for approximately 25 percent of

SMI revenues. The remainder is paid from general revenue—essentially income taxes. By law the SMI trust fund may draw as much general revenue as it needs to cover its costs.

The SMI trust fund is always in balance, but that tells us nothing of interest. The Trustees project that federal spending under Part B and Part D will continue to grow rapidly, gobbling up more resources and exerting increasing pressure on the economy.

To measure the combined fiscal impact of HI and SMI, the Trustees account for the flow of general revenue into Medicare (including money that could be infused into HI after its insolvency date). The rationale is that greater inflows of general revenue into Medicare leave that much less to finance other federal programs and priorities.

The 2011 Trustees report indicates that $24.4 trillion in general revenue must be transferred to the Medicare trust funds if the program is to pay all of its bills over the next 75 years.[2] About $38.4 trillion is required to fully finance Medicare indefinitely.

These estimates show that Medicare will not be able to fulfill its promises to future generations of seniors without significant changes in policy. However, long-term estimates such as these do not provide a sense of when the fiscal crisis is likely to occur and do not provide a clear impetus for action.

How the Funding Warning Works

The Medicare Modernization Act of 2003 attempted to provide a measure of the program's fiscal status that would trigger legislative action to correct an imbalance in the program's financing. It created a cost containment mechanism based on the amount of general revenue that funds the program.[3] The Trustees declare that general revenue funding is "excessive" when it funds more than 45 percent of total Medicare outlays within a seven-year time frame. Two successive findings of "excessive general revenue Medicare funding" trigger a "Medicare funding warning." The law requires the president to respond by submitting legislation within 15 days of his annual budget request in the year following the Trustees' warning. The first finding of excessive general revenue funding was made in 2006 and the first Medicare funding warning was issued in 2007.

There are two major problems with this Medicare trigger mechanism. First, there is no actuarial basis for choosing 45 percent as the point at which general revenue funding is excessive. The 45 percent mark could just as well have been higher or lower, but that does not invalidate its use.

High levels of general revenue funding in Medicare signal a program whose costs are higher than its revenue from payroll taxes and premiums, but that has been true since Medicare's inception. According to the 1970 Trustees report, general revenue accounted for about 24 percent of total program spending.[4] Medicare has never been fully self-financed, and such an objective may be unrealistic in an aging society.

How much should workers be expected to pay for benefits for seniors? The 45 percent mark provides one answer to the question, but that is a judgment call over which reasonable people could differ. Nonetheless, this is a question that we as a society must answer.

This has profound significance, not only for how we finance Medicare but also for the way we allocate scarce resources among competing priorities. Debates over Medicare policy too often ignore the trade-off between Medicare spending and the money available for education, housing, the environment, and other policy areas. The funding warning trigger could be a tool for ensuring that we maintain a balance in financing not just Medicare but also programs intended to meet the needs of young and old alike.

Second, the Medicare funding warning does not have any teeth. This is a particular problem when the purpose of the warning is to prod reluctant policymakers into taking difficult but necessary actions. Although the law requires the president to send a proposal to Congress, both the Bush and Obama administrations have argued that the Constitution protects him from that obligation.[5] Congress also did not bind its hands with the funding warning, requiring only expedited consideration rather than actual legislation. Although it may have raised attention to the issue, the funding warning has been ineffective in controlling Medicare spending.[6]

Medicare's Fiscal Condition Remains Critical

Despite White House claims that the new health reform law keeps Medicare strong and solvent, the Patient Protection and Affordable Care Act (PPACA) only modestly improved the program's fiscal outlook.[7] According to the Trustees, spending from the HI trust fund has exceeded revenue since 2008 and trust fund assets will be exhausted in 2024. SMI spending is projected to moderate somewhat from past trends, but the drain on the Treasury remains extremely high.

In fact, the estimates the Trustees used to determine whether to issue the funding warning are optimistic. They incorporate net Medicare savings from PPACA of $575 billion through 2019, primarily through reductions in payments to providers, that Medicare's actuary considers unrealistic.[8] The estimates also assume that Medicare payments to physicians will be cut an unprecedented 30 percent in January 2012.

Neither assumption is plausible. Even the Trustees state that "the actual future costs for Medicare are likely to exceed those shown by the current-law projections" contained in their report.

Congress will almost certainly intervene to prevent the worst consequences of arbitrary payment cuts. Unless the law is changed, increasing numbers of providers will drop out of the program as payment rates drop every year without relief.[9] About 15 percent of hospitals and other institutional providers will face negative profit margins by 2019, with that number rising to 25 percent by 2030. The loss of that capacity would compound the challenge of ensuring adequate access to health services that Medicare faces with the influx of baby boomers into the program.

The physician payment reductions scheduled under the sustainable growth rate (SGR) are equally unlikely to take effect. Congress has acted multiple times since 2003 to overturn even modest reductions in Medicare's payment update.[10]

The actuary estimates much higher levels of Medicare spending assuming that Congress rescinds those cuts.[11] According to that analysis, total Medicare spending will be 8 percent higher than the official estimate in 2020 and 14 percent higher in 2030, with spending growth continuing to accelerate beyond that point. That translates into trillions of dollars of additional general tax revenue that will be needed by Medicare unless responsible policies are adopted to reduce program costs.

Triggering a Policy Response

As we have seen, the president can ignore a Medicare funding warning with impunity. Even when a proposal is advanced (as President Bush did in 2008), there is no requirement that it address the fundamental cost drivers in Medicare. There are no immediate consequences if Congress fails to enact the legislation, and there may even be a voter backlash if Congress does take action.

This is a trifecta of inadequate legislative process, but toughening the process will not automatically solve the problem. Even a weak trigger could promote useful political debate leading to legislation, but all sides must rise above politics and take the fiscal problem seriously. This will only happen if the public makes it clear that business as usual in Washington is no longer acceptable.

The president and Congress do not need a Medicare funding warning to become aware of the program's financial circumstances. The Trustees have been warning us for many years that Medicare faces unprecedented fiscal pressures as the baby boom generation leaves the work force and enters the program. Over the course of the next two decades, some 70 million people will move from paying into Medicare to drawing benefits.

The president and Congress do not need an additional legislative vehicle to advance responsible policy proposals. The president's annual budget proposal should contain provisions that set Medicare on a sustainable fiscal path, and he should focus his energies on finding common ground with Congress to make Medicare reform a reality. Congress does not have to wait for the president to advance its own ideas for stabilizing Medicare's financing and improving its value to patients.

The importance of this issue cannot be overstated. Decisions about Medicare financing, whether by conscious policy or by default, will determine the fate of a program that millions of seniors depend on. Those decisions will also shape the limits on federal support for society's other priorities. Rapid growth in Medicare spending is a major contributor to the nation's debt crisis. Failure to adopt structural reforms to promote greater efficiency in delivering health care services and higher value for our Medicare dollar has impacts well beyond current beneficiaries of the program. The Medicare trigger could be a tool for ensuring that we provide for the needs

of seniors without neglecting other spending priorities (such as education, housing, and employment) that affect everyone's welfare.

The president and Congress may not need the trigger to take necessary policy actions, but past legislation has only tinkered around the edges of the current program rather than advancing more fundamental changes in the incentives that drive Medicare. Until the legislative process takes into account the long-term consequences of short-term policy actions (and inactions), we have no assurance that Medicare can be saved.

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[1] Hinda Chaikind, Jim Hahn, Jennifer O'Sullivan, and Henry Cohen, *The President's Proposed Legislative Response to the Medicare Funding Warning*, Congressional Research Service, Report RL34407 (April 3, 2008), available at http://stuff.mit.edu/afs/sipb/contrib/wikileaks-crs/wikileaks-crs-reports/RL34407.pdf.

[2] Calculated as the sum of HI (Part A) unfunded obligations plus general revenue contributions for Parts B and D from Tables III.B10, III.C15, and III.C23 in Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (May 13, 2011), available at https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf. All figures are present values as of January 1, 2011.

[3] See Title VIII, Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-17, available at http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf.

[4] Author's calculation based on Table 5b of the 1970 Trustees report for the Federal Hospital Insurance Trust Fund and Table 7 of the 1970 Trustees report for the Federal Supplementary Medical Insurance Trust Funds, available at http://www.ssa.gov/history/reports/trust/1970/1970hos.pdf and http://www.ssa.gov/history/reports/trust/1970/1970sup.pdf.

[5] Julian Pecquet, "Rep. Ryan knocks Obama for not shoring up Medicare funding," Healthwatch (March 1, 2011), available at http://thehill.com/blogs/healthwatch/medicare/146821-republicans-say-obama-administration-ignoring-medicare-solvency-warning.

[6] There are also technical problems that could bias the selection of policy proposals if the Medicare funding warning ever resulted in legislation. Increases in dedicated revenue (such as raising the Part B premium) have a greater impact on reducing ratio of general revenue to outlays than an equivalent reduction in program spending. In addition, increasing dedicated revenue by raising payroll taxes would have no impact on Medicare spending. Consequently, spending could continue to rise unabated as long as taxes were raised in tandem. See Hinda Chaikind and Christopher M. Davis, *Medicare Trigger*, Congressional Research Service, Report RS22796 (January 15, 2009), available at http://stuff.mit.edu/afs/sipb/contrib/wikileaks-crs/wikileaks-crs-reports/RS22796.pdf.

[7] "Affordable Care Act Update: Implementing Medicare Cost Savings," Centers for Medicare and Medicaid Services, Memorandum (undated), available at http://www.cms.gov/apps/docs/ACA-Update-Implementing-Medicare-Costs-Savings.pdf. See also Mike Lillis, "White House touts health reform's Medicare savings, defends math," Healthwatch (August 2, 2010), available at http://thehill.com/blogs/healthwatch/health-reform-implementation/112205-white-house-touts-health-reforms-medicare-savings-defends-math.

[8] Richard S. Foster, "Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended," Centers for Medicare and Medicaid Services, Memorandum (April 22, 2010), available at http://www3.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

[9] 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, Memorandum (May 13, 2011), available at http://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf.

[10] Jim Hahn, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, Congressional Research Service, report R40907 (August 6, 2010), available at http://assets.opencrs.com/rpts/R40907_20100806.pdf.

[11] The alternative estimate assumes the SGR is abolished and so-called productivity adjustments that lower payment rates to other providers are phased out after 2020. See Shatto and Clemens (2011).

Mr. GOWDY. Mr. Capretta.

STATEMENT OF JAMES C. CAPRETTA

Mr. CAPRETTA. Mr. Chairman, Mr. Davis, members of the subcommittee, thank you for the opportunity to participate in this very important hearing. In the short time available, I want to focus my comments on the reason the trigger was proposed in the first place and adopted by Congress, and why a credible reform of Medicare is so important.

The Medicare program, as we've just heard, is financed in ways that are not often well understood. Part of the program, as Dr. Blahous said, is financed like Social Security, but a big part of the program is not. For Parts D and B of the program, the beneficiaries pay premiums for a portion of the cost, but a large part is financed directly out of the general fund of the Treasury. These general fund payments to Medicare are not trivial. As I show in chart 1 in my prepared testimony, the present value of these payments, as estimated by the Medicare trustees, is expected to exceed $21 trillion over the long-range projection period.

Financing Part B and D in this manner can be deceptive in terms of the burden on taxpayers. Officially these parts of Medicare are always solvent. The trust fund that pays these benefits is never expected to ever be depleted because it by definition has always got money from the general fund to cover its costs. But just because the trust funds appear to be solvent on paper does not mean that there is no cost to this open-ended tap on the Treasury. The money must come from somewhere. When Part B and D costs rise, the general fund is tapped for more funding, it just means the Federal budget goes deeper into deficit, thus forcing more borrowing and debt.

One way to look at the burden of the general fund financing of Medicare places on the rest of the budget is to look at the amount of financing—of the financing relative to personal and corporate income taxes. In my prepared testimony I show in chart 2 that as recently as 1990, the general fund contribution to Medicare Part B took up only 5.9 percent of total personal and corporate income tax collections. By 2020, with Part D now part of the program, that figure had risen to 19.2 percent. So 1 out of every $5 coming into the Treasury in personal and corporate income taxes goes as a payment to the Medicare program. By 2050, it's getting closer to about 1 out of every $4.

And this is a very optimistic scenario. This is based on the official Medicare trustees' projections under current law, but that is highly unlikely to occur, as the actuaries themselves have stated repeatedly. In the new health care law, there is a very broad and deep reduction in the provider payment rates, what are called the productivity adjustment. This is going to hit hospital and other institutional providers of care every year in perpetuity. And the actuaries assume essentially that it won't happen because the consequence would be that many hospitals would stop seeing Medicare patients eventually. It would drive Medicare payments down to those of Medicaid and below, and reach at some point in the not-too-distant future 50 percent of what private insurers have to pay to access hospital coverage.

So the actuaries have produced an alternative scenario to say what is it going to look like if those kind of cuts don't go into place and the physician cut of 30 percent doesn't begin in next year. The result of that is shown in chart 3 of my prepared testimony. And the effect is that over the long run, total Medicare spending is essentially unchanged from where it was prior to enactment of the health law. In 2080, total Medicare spending would exceed 10 percent of GDP by that point in time, which is well above the 4 percent it is now, and certainly well above the 1 or 2 percent it was when the program was first enacted.

Now, the Medicare trigger was enacted to bring into the policy debate a broader view of Medicare's financing beyond the misleading picture of permanent solvency for Parts B and D. What's needed, though, at this point is, as Joe indicated, the will to actually enact a structural reform of the program. And here I would just like to conclude by pointing out that there seems to be some agreement that Medicare is key to slowing costs throughout the entire health system. As Mr. Blum testified, their view of the administration is that they need to change how Medicare operates with things like the accountable care organizations and bundled payments and other payment reforms.

It's my judgment that those proposals will not get very far because of the burdens of politics and other things that will stand in the way. What I think is more promising is actually reform like the Part D program has in Medicare. It is true that it has driven up the general fund contribution to the program, but it's built around competition and consumer choice. And the effect of that has been, since 2006 through 2010, the average annual per capita growth in cost has been just 1.2 percent, because the consumers have a very strong incentive to go with low-cost, high-value plans, and that has worked. It's my judgment that we should pursue Medicare reform in a broader way along those lines.

Thank you.

Mr. GOWDY. Thank you, sir.

[The prepared statement of Mr. Capretta follows:]

Testimony Presented to the Subcommittee on Health Care, District of Columbia, and National Archives of the House Committee on Oversight and Government Reform:

"The Medicare Trigger"

James C. Capretta
Fellow, Ethics and Public Policy Center

July 12, 2011

Mr. Chairman, Mr. Davis, and members of the Subcommittee, thank you for the opportunity to participate in this very important hearing on the statutory Medicare trigger.

In the short time available, I would like to focus my comments on the reasons the trigger was proposed and adopted by Congress in the Medicare Modernization Act of 2003 (MMA), and why a credible reform of the Medicare is so important for sustaining the program for future generations of seniors and for bringing about improvements in the broader health system.

The Nature of Medicare Financing Under Current Law

The Medicare program is financed in ways that are not often well understood. Part of the program -- for hospital insurance, or HI -- is financed much like the Social Security program, with a payroll tax that is dedicated to a trust fund from which hospital insurance claims are paid. When payroll taxes run short of paying for full hospital insurance benefits, then the program faces a funding shortfall and corrective steps must be taken to either increase HI revenue or decrease spending to keep the trust fund solvent

and paying full benefits. Currently, the Trustees for the Medicare program expect the HI trust fund to run out of reserves in 2024.

The other parts of Medicare -- for physician and outpatient services, and for coverage of prescription drugs -- are financed differently. Enrollees pay premiums for the coverage they get, but the premiums cover only a small portion of the total cost. In the case of part B (for physician and other non-institutional services), the beneficiary premiums have covered roughly 25 percent of total program costs (at enactment in 1965, the expectation was that beneficiary premiums would cover half of total part B program costs). The other 75 percent comes from the general fund of the Treasury. Similarly, for part D, beneficiary premiums and payments made by states to the federal government cover about 25 percent of the prescription drug program's total costs. The balance comes from the general fund of the Treasury.

These general fund payments to Medicare are not trivial. As shown in Chart 1, the present value of these payments, as estimated by the Medicare Trustees, is expected to exceed $21 trillion over the long-range projection period.

Chart 1:
General Fund Contributions to Part B and D of Medicare

Present Value of General Fund Contributions to Medicare Parts B and D*	
	$ Trillions
Part B	13.9
Part D	7.5
Total	21.4

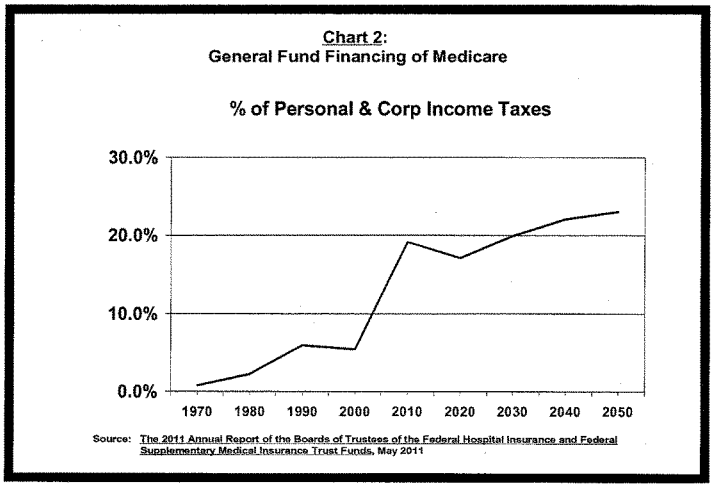
*Covering the long-range (75-year) projection period

Source: The 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical insurance Trust Funds, May 2011

Financing part B and part D in this manner can be deceptive in terms of the burden on taxpayers. Officially, these parts of Medicare are "solvent." The trust fund that pays these benefits is not expected to ever be depleted because it is, by definition, always solvent. No matter the total cost, enough is drawn every year from the general fund to ensure part B and part D benefits are paid in full.

But just because the trust funds look to be "solvent" on paper does not mean that there is no cost to this open-ended tap on the Treasury. The money must come from somewhere. When part B and part D costs rise, and the general fund is tapped for more funding, it just means that the total federal budget goes deeper into deficit, thus forcing more borrowing and debt.

One way to look at the burden that general fund financing of Medicare places on the rest of the budget is to look at the amount of this financing relative to the total of personal and corporate income taxes, which are the main source of government revenue for programs without a dedicated funding source. As shown in Chart 2, as recently as 1990, the general fund contribution to Medicare part B took up only 5.9 percent of total personal and corporate income tax collections. By 2010 (with part D now also part of the overall program), the percentage had risen to 19.2 percent. By 2050, the Trustees expect the percentage to reach 23 percent.

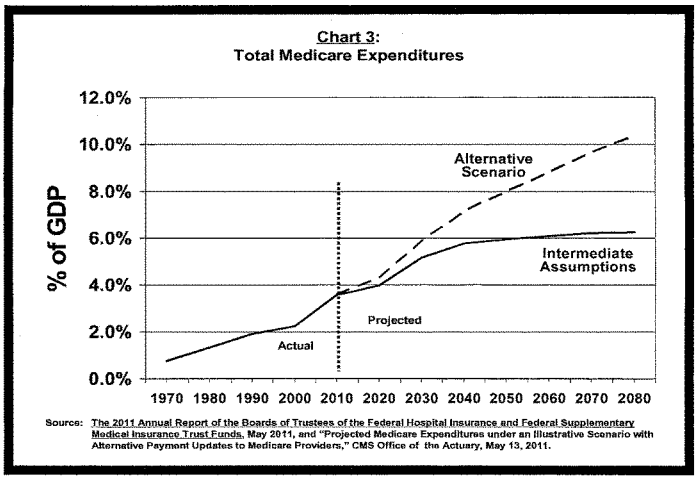


And this is a very optimistic scenario. The Medicare Trustees' official projections (using what are known as intermediate assumptions) presume that the current law payment rates for physician services will continue indefinitely into the future. This is highly unlikely to occur, as there is strong bipartisan opposition to the scheduled, deep

cuts in physician fees that are to take place beginning in 2012 under current law. Those cuts have been reversed by Congress repeatedly over the past decade, and the actuarial office for the Medicare program expects them to be reversed in the future as well.

Moreover, the health law enacted in 2010 imposed other reductions in the Medicare program to partially finance the entitlement expansions contained in that legislation. Those cuts hit other providers of services, some of whom are paid by the part B account. The actuaries at the Medicare program believe it is very likely that these cuts will be reversed as well because, if they are allowed to stand, they will force many hospitals and other providers to limit their participation in Medicare to limit their losses.

To help gauge what Medicare's finances will look like if these cuts are reversed, the actuaries have produced an "Alternative Scenario" for Medicare's finances that differs from the official projections in the 2011 Trustees' report. As shown in Chart 3, this alternative scenario reveals that Medicare's long-term spending trajectory is likely to be far worse than the official projections, with total Medicare spending exceeding 10 percent of GDP by the end of the projection period, compared to just over 6 percent in the official projections. Under this alternative scenario, the draw on the general fund for parts B and D of Medicare would be substantially higher than under the official projections as well.



The Role of the Trigger

The "Medicare Trigger" was enacted to bring into the policy debate a broader view of Medicare's finances, beyond the misleading picture of permanent solvency for parts B and D.

The trigger monitors total Medicare spending relative to the share of the program that is financed by the general fund. When the Trustees project that the share will exceed 45 percent two years in a row, the trigger goes off, and a process is set in motion to begin consideration of reforms to bring general revenue funding of Medicare below the threshold.

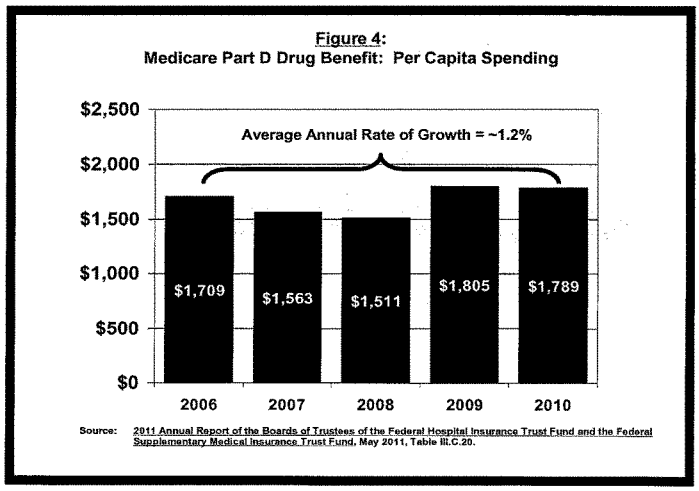
Structural Reform of Medicare Is Needed to Slow Rising Costs

There seems to be a level of bipartisan agreement on the need for fundamental reform of the Medicare program. The proponents of the 2010 health law have often said that it contains many provisions to "bend the cost curve." Those provisions, it turns out, are mainly aimed at changing how Medicare operates today. For instance, the new law authorizes Accountable Care Organizations and other payment reforms to move away from unmanaged fee-for-service insurance. So, at some level, there is consensus that an important component of the cost challenge is to change the incentives that are now prevalent in the Medicare program.

That makes sense. Medicare is the dominant payer in most markets. The delivery system has been built up around the incentives that Medicare provides. Therefore, it will be very difficult to establish a more efficient and productive health sector if Medicare does not change.

But the question is, what direction should reform take? The new health law adopts a regulatory approach, with the bureaucracy overseeing the program trying to micromanage its way to a more efficient program. That has not worked in the past. What has happened is that the bureaucracy finds it impossible to make distinctions among providers of service based on quality. So, to hit budget targets, it imposes across-the-board payment rate reductions instead. That is very likely to occur this time as well.

I believe what is necessary is a more far-reaching reform of the program, modeled on the successful part D prescription drug program. While that program did increase the government's general fund contribution to Medicare, it also introduced into Medicare a new way of structuring the insurance benefit. The government does not micromanage part D prices but provides a fixed level of support for coverage based on weighted-average premium of the competing plans. Importantly, the government's contribution does not rise with the expense of a plan. That feature gives participants a strong incentive to find the best value they can so that the premium they must pay is kept to a minimum. This structure has worked very well to hold down annual increases in cost growth. As shown in Chart 4, the average annual per capital increase in part D costs has been about 1.2 percent over the period 2006 to 2010.



Conclusion

Medicare is a very important program for the nation's seniors. The "Medicare Trigger" was put in place to help policymakers strengthen the program so that is can be sustained over the coming decades and continue to provide insurance protection for future generations of retirees. That can be achieved with a reform that protects current recipients from unnecessary disruption even as it harnesses the power of a functioning marketplace to deliver higher value at an affordable price for future program participants.

Mr. GOWDY. Dr. Van de Water.

STATEMENT OF PAUL N. VAN DE WATER

Mr. VAN DE WATER. Mr. Chairman, Mr. Davis, I appreciate the invitation to appear before you today.

Although Medicare faces significant financing challenges, claims by some policymakers that the program is facing bankruptcy are highly misleading. The 2011 report of the Medicare trustees shows little change from last year's report. Because the trustees now foresee a slower recovery, they estimate that Medicare's Hospital Insurance Trust Fund will be depleted in 2024, 5 years sooner than they estimated last year. Even at the point of depletion, however, payroll taxes and other revenues will still be sufficient to pay 90 percent of HI costs.

HI will not be completely lagging in resources, nor does it face going out of business. And the 2024 date does not apply to the Medicare Supplementary Medical Insurance Trust Fund. SMI is always adequately financed because beneficiary premiums and general revenue contributions are set annually to cover expected costs for the coming year. By design, SMI cannot run out of money.

The trustees' near-term projections are broadly in line with those they have issued in the past. Since 1990, changes in the law, the economy and other factors had moved the projected year of HI insolvency as close as 4 years and as far as 28 years away. Trustees reports, in fact, have been projecting insolvency for four decades, but Medicare benefits have always been paid because Congress has taken steps to make sure that they are. The rapid evolution of the health care system has required frequent adjustments to Medicare as it has to private health insurance, and that pattern is certain to continue.

Although the trustees again project that 45 percent or more of Medicare's financing will come from general revenues within 6 years, this finding bears no relation whatever to Medicare solvency. The 45 percent figure is an arbitrary benchmark that is completely unrelated to the financial health of the program. By its very design, Medicare is supposed to be financed in large part with general revenues. That at least 45 percent of Medicare will be financed with general revenue is no more a problem than that 100 percent of defense, education and most other Federal programs will also be financed with general revenues.

Last year's health reform legislation significantly improved Medicare's long-term cost outlook. If health care were repealed, the Medicare actuary estimated that HI's insolvency date will be moved up 8 years to 2016. And without health reform, HI's long-term shortfall would increase from 0.79 percent of payroll to 3.89 percent. These projections underscore the importance of successfully implementing the cost-containment provisions in the Affordable Care Act.

In contrast, phasing out traditional Medicare and replacing it with private health insurance, as the House-passed budget resolution would do, would represent a big step in the wrong direction. It would increase total health care spending attributable to Medicare beneficiaries by upwards of 40 percent, and it would reduce the Federal Government's contribution to cover those costs. As a re-

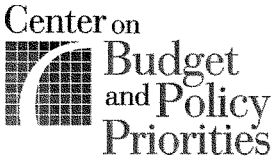
sult, the House plan would massively shift costs to elderly and disabled beneficiaries. According to CBO, the average 65-year-old beneficiary's out-of-pocket spending would more than double from about $6,000 a year to over $12,000 in 2022.

Health reform envisions that Medicare will continue to lead the way in efforts to slow health care costs while improving the quality of care. By eliminating traditional Medicare, the House-passed plan would discard the opportunity to use the program to promote cost reduction throughout the health care system. Americans should not be driven into adopting such a radical proposal by misleading claims that Medicare is on the verge of bankruptcy.

Thank you, Mr. Chairman.

Mr. GOWDY. Thank you.

[The prepared statement of Mr. Van de Water follows:]



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TESTIMONY OF PAUL N. VAN DE WATER
Senior Fellow, Center on Budget and Policy Priorities

Before the
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
U.S. House of Representatives

Financial Status of the Medicare Program

Mr. Chairman, Mr. Davis, and members of the subcommittee, I appreciate the invitation to appear before you today.

Although Medicare faces significant financing challenges, claims that the program is nearing "bankruptcy" are highly misleading. The 2011 report of Medicare's trustees shows little change from last year's report in the financial outlook for the program. Partly because the trustees now foresee a modestly slower economic recovery that will reduce Medicare payroll tax revenues relative to earlier estimates, they estimate that Medicare's Hospital Insurance (HI) trust fund will be depleted in 2024 — five years sooner than they projected last year.

Even at the point of depletion, however, payroll taxes and other dedicated revenues will still be sufficient to pay *90 percent* of HI costs. HI will not be completely lacking in resources, although additional revenues or programmatic changes clearly will be needed to restore financial balance. And the 2024 date applies only to Medicare's Hospital Insurance trust fund and not to the Supplementary Medical Insurance (SMI) trust fund, which finances physician services and prescription drug coverage. SMI is always adequately financed because beneficiary premiums and general revenue contributions are set annually to cover expected costs for the coming year. By construction, SMI cannot run short of money — or go "bankrupt."

The trustees' near-term projections are broadly in line with those they have issued in the past. Since 1990, changes in the law, the economy, and other factors have moved the projected year of HI insolvency from as close as four years to as far as 28 years away. Trustees' reports have been projecting insolvency for four decades, but Medicare benefits have always been paid because Congress has taken steps to make sure that they are. The rapid evolution of the health care system has required frequent adjustments to Medicare, as it has to private health insurance, and that pattern is certain to continue.

Although the trustees again project that 45 percent or more of Medicare funding will come from general revenues within six years, this finding bears no relation whatever to Medicare's solvency. The Medicare Modernization Act of 2003 established a process for issuing a "Medicare funding warning" when the share of Medicare financing from general revenues is projected to exceed 45 percent. The 45-percent level, however, is a completely arbitrary benchmark that is entirely unrelated to the financial health of the program. By its very design, Medicare is supposed to be financed in significant part with general revenues. That at least 45 percent of Medicare will be financed with general revenues is no more a problem than that 100 percent of defense, education, or most other federal programs is financed with general revenues.

Over the next 25 years total Medicare spending is projected to grow at about the same rate as the trustees forecast previously — from 3.6 percent of gross domestic product (GDP) in 2010 to 5.6 percent of GDP in 2035. Much of this projected increase stems from the aging of the baby boomers, the first of whom become eligible for Medicare this year. This shift in the age distribution of the population has long been anticipated and inevitably brings with it an increase in health care spending, since health care needs and costs increase as people get older.

Last year's health reform legislation (the Affordable Care Act, or ACA) significantly improved Medicare's long-term cost outlook. Over the next ten years, Medicare spending per beneficiary is projected to grow by 3.0 percent a year, well below both its average of 7.8 percent a year over the previous decade and also the projected rate of growth of private health care costs. Under the trustees' main projection, the HI program's 75-year shortfall is 0.79 percent of taxable payroll — up from last year's estimate of 0.66 percent of payroll, but much less than without health reform.

If health reform were repealed, the Medicare actuary has estimated that HI's insolvency date would be moved up eight years, to 2016. Without health reform, HI's long-term shortfall would increase from 0.79 percent to 3.89 percent of taxable payroll.

These projections emphasize the importance of successfully implementing the cost-control provisions of the Affordable Care Act. While history shows that most major Medicare savings measures have been implemented as scheduled, the Medicare actuary has expressed concern that some of the ACA's savings provisions may not be sustainable. The actuary urges reliance instead on an "illustrative alternative" projection for Medicare, which assumes that only 60 percent of the ACA's Medicare savings will be achieved in the long run. Using this alternative projection would not affect the projected insolvency of the Hospital Insurance trust fund, which would still occur in 2024, but the 75-year shortfall in the fund would rise to 2.15 percent of payroll — about 2¾ times higher than the trustees' official estimate. This is still a dramatic improvement, however, over the situation *prior* to the Affordable Care Act.

Despite the improvements made by the Affordable Care Act, Medicare continues to face significant long-term financial challenges, stemming from the aging of the population and the continued rise in health care costs throughout the U.S. health care system, which contributes to the bleak federal fiscal outlook. It is essential that policymakers take further substantial steps to curb the growth of health costs throughout the U.S. health care system as we learn more about how to do so effectively in both public programs and private-sector health care. In particular, the Medicare research and pilot projects the ACA establishes should yield important lessons.

In the near term — before these efforts bear fruit— it will be difficult to achieve big additional reductions in Medicare expenditures without shifting substantial costs to beneficiaries or greatly reducing payments to providers, either of which would likely endanger access to care for low- and moderate-income beneficiaries. Extending the life of the HI trust fund will almost certainly require *both* increases in HI revenues *and* further reductions in projected Medicare expenditures.

Phasing out traditional Medicare and replacing it with private health insurance, as the House-passed budget resolution would do, would represent a big step in the wrong direction. It would increase total health care spending attributable to Medicare beneficiaries (the beneficiaries' share plus the government's share) by upwards of 40 percent, according to the Congressional Budget Office. It would also reduce the federal government's contribution to cover those costs. As a result, it would massively shift costs to the beneficiaries — that is, the elderly and persons with disabilities.

Traditional Medicare — not private health insurance — has been the leader in instituting various reforms in the health care payment system to improve efficiency. Partly because of its record of innovation, Medicare has outperformed private insurance in holding down the growth of health costs. Between 1970 and 2009, Medicare spending per enrollee grew by an average of 1 percentage point less each year than comparable private health insurance premiums. Under health reform, Medicare will continue to lead the way in efforts to slow health care costs while improving the quality of care. By eliminating traditional Medicare, the House-passed plan would discard the opportunity to use the program to promote cost reduction throughout the health care system. Americans should not be driven into adopting such a radical proposal by incorrect claims that Medicare is on the verge of "bankruptcy."

Mr. GOWDY. Dr. Blahous, what in your judgment is the single best policy that you could recommend in order to improve Medicare solvency?

Mr. BLAHOUS. I have to be a little bit careful in answering that question. Obviously as a trustee, we don't have an official view, and I'm not speaking for the other trustees. I would just make a couple of comments. One is certainly there is a robust debate about how we can get more savings in order to achieve actuarial balance in Medicare. We have a shortfall in Medicare. There's competing ideas on how to resolve the remaining shortfall.

Mr. GOWDY. Before you finish that, because I may be making an assumption that you disagree with, do you agree with Dr. Van de Water that all of this is just worrying about nothing, and that everything is going to be fine, and we can continue to fund it from the general fund, and it's no big deal?

Mr. BLAHOUS. I don't agree that it's no big deal. I think we have a very substantial financing challenge in Medicare, a sizable problem remaining to solve, and I'm very concerned about it.

Mr. GOWDY. All right. Go on with your solution.

Mr. BLAHOUS. Well, I would say that one of the things that's difficult is getting savings from a program that people are dependent upon. And this one of the things that causes people on both sides of the aisle to have disagreements, how can we get savings which we need from the Medicare program without sacrificing beneficiary access to care.

What I can say is that it's easier to hold down spending growth where people have not yet become dependent on a program. If I just give one piece of advice personally, I would say do what can be done to slow down or scale back the spending increases in last year's health care reform law. Basically, to the extent that we show an improvement in Medicare financing under that law, it's because of the Medicare provisions alone understood in isolation, but that law contained other provisions that expended a great deal of that projected savings in Medicare, about 63 percent of it according to CBO. To the extent that we expend that savings in Medicare on a new program, we are undercutting the government's ability to make good on those increased funding obligations to Medicare.

So I think my short answer would be do whatever can be done to scale back the projected spending increases outside of Medicare from last year's health care law.

Mr. GOWDY. Well, that leads nicely, I think, to my next question for you, Dr. Antos. Do you agree with the administration that the trigger mechanism, that's just a suggestion or an advisory idea, or do you believe that it is a legal requirement that they submit a plan?

Mr. ANTOS. It's a law.

Mr. GOWDY. That's what I thought, too.

Do you think that ObamaCare complies with that requirement of the law?

Mr. ANTOS. Well, it certainly does not comply with the technical specifications of the law. The law clearly states that in response to the funding warning, the President is to send to Congress his proposal within 2 weeks of his budget.

Now, I think it may be a little unclear at least in the abstract if the President's budget, in fact, addressed this problem, whether that was a sufficient response. However, in my opinion, the President's budget at this time did not address the problem.

Mr. GOWDY. Mr. Capretta, I've thought about patenting or getting a trademark on Paul Ryan's name so I could be paid every time it is mentioned in a committee hearing in Washington. I haven't yet.

A lot of criticism about Representative Ryan's plan. The other plan, near as I can tell, is just to continue to raise the debt ceiling as often as we can. What are your thoughts on his plan, and do you have a better idea.

Mr. CAPRETTA. I don't have a better idea. I think his plan is really very much the direction we need to head.

I would say a couple of things about some of the criticisms that are made about it. First is there's often reference to a CBO analysis of what the Ryan plan would do in 2022. A couple of things about that. First, it assumes that the payment rate reductions that occur in Medicare through ObamaCare are going to be in place all the way to 2022. So in a sense it creates—it says that we're going to impose very deep price reductions in what Medicare pays for services, price reductions that would bring Medicare's rates down below Medicaid by the end of the decade, and assumes those will be in effect in 2022, and that Medicare beneficiaries will still have access to care in 2022 at the rates they do today. Highly unlikely that that will occur.

So I think one assumption is just false, that you can have—you know, you could pay as low as you want in Medicare with no consequence whatsoever on quality. I think that's a false assumption that's buried in those CBO numbers.

The second thing that it doesn't do is that it doesn't take into account any effect from competition. And Dr. Elmendorf testified at the House Budget Committee a week or so ago, 10 days ago, and said as much to Chairman Ryan, that that's a gap in their toolbox, that they don't estimate the effects of competition on what it will do to premiums in the future, and so they have no—the whole point of the Ryan proposal is to bring some discipline to the Medicare program, not to increase costs on seniors, but actually increase value so they can get a better deal, much like we did in the Part D program.

So I generally reject the notion that the Ryan plan is actually going to be worse for seniors. The whole point of it is to actually make it better for seniors without the problems that come from price controls.

Mr. GOWDY. Thank you.

My time is expired. The gentleman from Illinois Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

The Republican Federal budget proposal for fiscal year 2012, widely known as the Ryan plan, was passed by a party-line vote in the House of Representatives on April 15, 2011. The Ryan plan would end Medicare as it exists today, take away all Federal health benefits from 65- and 66-year-olds and give 67-year-olds and older a voucher that will pay a smaller and smaller share of their health care costs.

According to the Congressional Budget Office's long-term analysis of the Ryan plan, this proposal would result in substantially higher out-of-pocket costs for seniors. CBO found that they would be paying 68 percent of the health care costs, more than double what they pay now under traditional Medicare. This massive shift in cost from the government onto individuals would cause many seniors to forego health care altogether. Those that could would sign up for welfare programs.

Dr. Blahous, Chairman Ryan represents this radical transformation he is leading as, and I am quoting, preserving and protecting Medicare. But any student of history could know that Republicans opposed the creation of Medicare in the 1960's and have sought to dismantle it since then.

Dr. Blahous, are you familiar with this quote from former Republican National Committee Chairman Haley Barbour, who extolled the 1995 trustees report as manna from Heaven in an effort to politicize Medicare and justify then-Speaker Gingrich's Contract with America plan to cut Medicare spending by 14 percent to provide tax cuts for the rich?

Mr. BLAHOUS. I was not familiar with that quote, sir, no.

Mr. DAVIS. Okay. If you heard such a quote, would you agree with it, have any concerns about it, or have a different position and a different opinion?

Mr. BLAHOUS. Well, certainly speaking as someone who I feel very honored to have become a trustee last year, it will certainly be my hope that the trustees reports be received in a spirit so that they inspire changes to make financial corrections to preserve the financial soundness of the Medicare program. The purpose of the trustees report is to acquaint Congress and the public with the finances of Medicare to permit the program to be as strong as possible.

Mr. DAVIS. Mr. Van de Water, can I ask you, under the Ryan proposal, the Congressional Budget Office determined that the gradually increasing number of Medicare beneficiaries participating in the new premium support program would bear a much larger share of the health care costs than they would under the traditional program. That greater burden would require them to reduce their use of health care services, spend less on other goods and services, or save more in advance of retirement than they would under current law. At the same time the proposal analyzed by CBO would leave in place provisions restraining payments to many providers under the traditional Medicare program. Under this scenario where our seniors who are living on a fixed income are supposed to get additional money they need to obtain health care and take care of their basic needs like food, shelter and clothing, won't all of this put an even bigger burden on seniors themselves and their children who might be helping out?

Mr. VAN DE WATER. Yes, I think that's correct, Mr. Davis. As you or another one of the Members, I believe, has already cited, that the Congressional Budget Office analysis of the budget resolution plan would roughly double the expected out-of-pocket costs for a typical 65-year-old in the first year from about $6,000 to over $12,000 a year. And given the average income of a 65-year-old, that increase would be a significant burden.

Mr. DAVIS. A big burden.

Mr. Chairman, I see my time is expired.

Mr. GOWDY. I thank the gentleman from Illinois.

The chair would now recognize the gentleman from Connecticut Mr. Murphy.

Mr. MURPHY. Thank you very much, Mr. Chairman. And I thank the panel for being here with us today.

Representative Davis, as I will, spent some time talking about the Ryan budget, the budget that passed through the House of Representatives. And I think it's appropriate, because what the subject of today's hearing is really about is who has the burden of making proposals to try to reform our Medicare program going forward. And that's a really important topic for us to be talking about.

I mean, we have one very clearly articulated plan before Congress right now, and that is the Republican budget, which dramatically changes the Medicare program, and admittedly certainly takes cost out of it, but takes cost out of it by shifting the burden onto individuals, tripling the amount of out-of-pocket costs for senior citizens, for example.

But one of the other things it does—and, Dr. Van de Water, I will ask you a question about this because I know you've spent some time looking at it—what it also does is it removes 65- and 66-year-olds from eligibility for the program. And maybe this doesn't seem like such a big deal. It's sort of built in this mythology that people are living longer. It's not necessarily that over the last few years people are living longer, it's that less infants are dying, and so you still have people retiring, leaving work at about the same age and needing benefits.

Medicare was conceived in part because those people who are 65 and 66 just didn't have a private market, didn't have a place to go to that could adequately insure someone that is likely going to be more sick. And the reality is that a lot of those people who are 65 and 66 and who don't—will not now qualify for Medicare are going to receive their care from somewhere else, that the cost is going to shift to somewhere else in the system.

And I guess I wanted to ask that question to you, Dr. Van de Water. What happens as you move millions of 65- and 66-year-olds off of Medicare? There seems to be an idea that the government won't bear that cost, but in reality we're likely to shift a lot of that health care cost just onto the government dime somewhere else. Could you speak a little bit about how the cost shifting for individuals who are removed from the Medicare rolls occurs?

Mr. VAN DE WATER. Yes, Mr. Murphy. I might say the proposal to increase or the discussion of increasing the Medicare eligibility age to 67 is problematic, but at least I think can sensibly be discussed if one is assuming that the Affordable Care Act goes into effect, because with the Affordable Care Act, at the very least 65- and 66-year-olds would have a guaranteed alternative source of coverage. Many beneficiaries would have to pay considerably more, but they wouldn't be completely shut out of the market.

But as we know, under the current arrangement, without the provisions of the Affordable Care Act, many people in their 60's find that insurance is either unavailable or completely unaffordable. And so the result is exactly as you say: If the eligi-

bility age were increased, some of the people in the 65- to 66-year-old bracket would go without insurance. To some extent they would cut back on care if they couldn't afford it. To some extent they would pay for it out of pocket, and to some extent it would end up being paid for through emergency room visits. And some people, of course, would be poor and would end up on Medicaid. So it would be shifted in a variety of fashions.

Mr. MURPHY. And I think that your point is a good one, which is that, though I don't support moving the retirement age up to 67, we did hear for a period of time in this Congress a mantra of repeal and replace, which was, I think, an effort, at least on behalf of those who opposed the health care bill that was passed by this Congress, to recognize that we needed something else in its place. We don't have that any longer; we just have repeal. And those that will be most exposed, as you mentioned, are those who are right on the cusp of Medicare eligibility. In fact, right now, even with the eligibility at 65, the people who are most likely to go without insurance if they lose their job are people who are in the 55 to 65 age bracket.

And so I do think that it's important to recognize how fragile the world is today for people right on the edge of Medicare eligibility and how incredibly increasingly fragile it becomes if you partner these drastic changes in the Ryan budget to Medicare with a full repeal of the Affordable Care Act.

And I see my time is up. I yield back.

Mr. GOWDY. I thank the gentleman. And all of us thank our four witnesses not only for lending us your perspective, your insight, your expertise, but also for accommodating a long vote series. I know your time is just as valuable as ours, if not more so, so we appreciate your courtesy. And thank you again for your presence today.

The hearing is adjourned.

[Whereupon, at 4:09 p.m., the subcommittee was adjourned.]

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