MEDICARE'S FUTURE: AN EXAMINATION OF THE INDEPENDENT PAYMENT ADVISORY BOARD

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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CONTENTS

MEDICARE'S FUTURE: AN EXAMINATION OF THE INDEPENDENT PAYMENT ADVISORY BOARD

TUESDAY, JULY 12, 2011

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10:05 a.m. in room 210, Cannon House Office Building, Hon. Paul Ryan [chairman of the committee] presiding.

Present: Representatives Ryan, Akin, Price, McClintock, Chaffetz, Stutzman, Lankford, Black, Ribble, Flores, Mulvaney, Huelskamp, Young, Amash, Guinta, Woodall, Van Hollen, Schwartz, Blumenauer, McCollum, Yarmuth, Pascrell, Wasserman Schultz, Moore, Castor, Tonko, and Bass.

Chairman RYAN. The committee will come to order. We will begin our hearing. Madam Secretary, I know how excited you are to be here today. Thank you for coming.

I will begin with some brief opening remarks, then I will turn it over to Mr. Van Hollen, and then we will get started.

First of all, I want to thank you, Madam Secretary, and our other panel of witnesses for coming to today's hearing on the future of Medicare. For years, politicians in both parties have not been honest with the American people about Medicare. The facts are clear. Health care costs are skyrocketing, growing at 8 percent a year. Medicare spending is on pace to double over the next decade, exhausting its remaining funds. Ten thousand baby boomers are retiring every day as fewer workers are left paying into the program. Life expectancy was at 70 when Medicare was created. Today it is 79. Nonpartisan experts, including the Congressional Budget Office and Medicare's own trustees, repeatedly warn of the looming insolvency of this critical program. These aren't Democratic facts, these aren't Republican facts. These are facts.

Rather than advancing solutions to address these facts, too many politicians from both parties in the past, in Washington, have offered nothing but empty promises and false attacks. We deserve better. Our seniors deserve better. Due in large part of this committee efforts, I believe that the debate is shifting to better reflect Medicare's inescapable math. President Obama was exactly right when he stated yesterday, "If you look at the numbers, Medicare in particular will run out of money and we will not be able to sustain that program, no matter how much taxes go up. It is not an option for us to just sit by and do nothing." I couldn't have said it better myself.

Senator Joe Lieberman, who has worked in a bipartisan manner to offer ideas of his own, put it well when he recently said, "We can only save Medicare if we change it."

The purpose of this hearing is to examine the changes to Medicare made by the President's health care law. Specifically, we wish to seek to better understand the Independent Payment Advisory Board's role in achieving the hundreds of billions of dollars of savings called for by the President. While I imagine we will hear about the many different expansions of government buried in this 2,700-page law, today's hearing is simply focused on page 1,000, section 3,403.

The Independent Payment Advisory Board, or IPAB, as we call it, is a new executive branch agency created by the President's new health care law. The law empowers this Board of 15 unelected officials with the authority to reduce Medicare spending. Unless overturned by a supermajority in Congress, the recommended cuts dictated by this Board will become law.

Bipartisan concerns have been raised with several aspects of this Board. While the proponents claim that the beneficiaries will be held harmless by the Board's decisions, how can IPAB impose sharp cuts to providers without an adverse impact on their patients? Given their unprecedented new power over Medicare, to whom are these 15 bureaucrats accountable?

There are bipartisan concerns on this question. Democrats, including some members of this committee, have raised concerns with Congress turning its responsibilities over to this Board. Seniors are also seeking clarity on the President's recent efforts to expand this Board's power over Medicare. In an April speech, the President called for IPAB to enforce further restrictions in Medicare's growth rate, down to GDP plus .5 percent. The health care law is already driving Medicare's reimbursement rates well below the artificially low Medicaid rates. According to Medicare's chief actuary, Richard Foster, the health care law will pay doctors less than half of what their services cost at the end of the decade, and down to 33 percent in decades ahead. Foster warns that these cuts are driving Medicare providers out of business and resulting in harsh disruptions to the quality and access for seniors.

Yet the President's framework calls upon IPAB to slash reimbursement rates even further than this. It remains incumbent upon the administration to specify how this Board will squeeze hundreds of billions of dollars of additional dollars from Medicare over the next decade, as the President has now proposed.

I want to thank Secretary Sebelius, I seriously do, for testifying today, for coming here to address these concerns. There is no question that we have differences on how to address Medicare's unsustainable future. But I appreciate your commitment to clarifying this debate for policymakers and for the American people.

I also want to thank our second panel of distinguished health care experts who will further discuss the merits of this approach. We look forward to testimony from former CBO Director, Doug Hotlz-Eakin, Grace Marie Turner of the Galen Institute, and Dr. Judith Feder of the Urban Institute. Thank you all of our witnesses for the contributions to this debate. And I want to thank you all for joining this conversation.

With that, I would like to yield to the ranking member, Mr. Van Hollen, for any opening remarks he may have.

[The prepared statement of Chairman Ryan follows:]

PREPARED STATEMENT OF PREPARED STATEMENT OF HON. PAUL RYAN, CHAIRMAN, COMMITTEE ON THE BUDGET

Thank you to all for taking part in today's hearing on the future of Medicare. For years, politicians in both political parties have not been honest with the American people about Medicare.

The facts are clear:

• Health care costs are skyrocketing, growing at 8% a year. Medicare spending is on pace to double over the next decade, exhausting its remaining funds.

• 10,000 baby boomers are retiring every day, as fewer workers are left paying into the program.

• Life expectancy was at 70 when Medicare was created, and is at 79 today.

• Nonpartisan experts—including the Congressional Budget Office and Medicare's own trustees—repeatedly warn of the looming insolvency of this critical program.

Rather than advancing solutions to address these facts, too many politicians in Washington have offered nothing but empty promises and false attacks. We deserve better.

Due in large part to this committee's efforts, I believe that the debate is shifting to better reflect Medicare's inescapable math. President Obama was exactly right when he stated yesterday: "If you look at the numbers, Medicare in particular will run out of money, and we will not be able to sustain that program no matter how much taxes go up. It's not an option for us to just sit by and do nothing."

Senator Joe Lieberman, who has worked in a bipartisan manner to offer ideas of his own, put it well when he recently stated: "We can only save Medicare if we change it." The purpose of today's hearing is to examine the changes to Medicare made by the President's health care law. Specifically, we will seek to better understand the Independent Payment Advisory Board's role in achieving the hundreds of billions of dollars of savings called for by the President. While I imagine we'll hear about the many different expansions of government buried in the 2,700-page law, today's hearing is focused is on page 1000, Section 3403.

The Independent Payment Advisory Board—or IPAB—is a new executive branch agency created by the President's healthcare law. The law empowers this board of 15 unelected officials with the authority to reduce Medicare spending. Unless overturned by a supermajority in Congress, the recommended cuts dictated by this board will become law.

Bipartisan concerns have been raised with several aspects of this board. While the proponents claim that beneficiaries will be held harmless from the board's decisions, how can IPAB impose sharp cuts to providers without any adverse impact on their patients?

Given their unprecedented new power over Medicare, to whom are these 15 bureaucrats accountable? There are bipartisan concerns on this question. Democrats, including members of this committee, have raised concerns with Congress turning its responsibilities over to this board.

Seniors are also seeking clarity on the President's recent efforts to expand this board's power over Medicare. In an April speech, the President called for IPAB to enforce further restrictions in Medicare's growth rate—down to GDP + 0.5%. The health-care law is already driving Medicare's reimbursement rates well below the artificially low Medicaid rates. According to Medicare's Chief Actuary Richard Foster, the health care law will pay doctors less than half of what their services cost at the end of the decade, and down to 33% in the decades ahead. Foster warns that these cuts are driving Medicare providers out of business and resulting in harsh disruptions in quality and access for seniors.

Yet the President's 'framework' calls upon IPAB to slash reimbursements even further. It remains incumbent upon the Administration to specify how this board will squeeze hundreds of billions of additional dollars from Medicare over the next decade, as the President has proposed.

I want to thank Secretary Sebelius for testifying today to help address these concerns. There is no question that we have differences on how to address Medicare's unsustainable future, but I appreciate your commitment to clarifying this debate for policymakers and for the American people.

I also want to thank our second panel of distinguished health care experts who will further discuss the merits of IPAB. We look forward to testimony from former

CBO Director Doug Holtz-Eakin, Grace-Marie Turner of the Galen Institute, and Dr. Judith Feder of the Urban Institute.

Thank you to all of our witnesses for their contributions to the debate, and to all for joining in today's discussion. With that, I yield to Ranking Member Van Hollen for his opening statement.

Mr. VAN HOLLEN. Well, thank you, Mr. Chairman. I want to join Chairman Ryan in welcoming you, Madam Secretary, to the panel and to the other witnesses we are going to hear from later. And I want to commend you on two initiatives you have recently undertaken to help implement the Affordable Care Act. One are the rules, guidelines that you recently released to govern the exchanges, which will open the door to millions of more Americans being able to get affordable health care in the United States of America. The other that received less attention is your recently announced initiative to improve the coordination of care for individuals who are both on Medicaid and Medicare, called the "dual eligibles." And as you have pointed out, using some of the innovative approaches in the Affordable Care Act, we can both improve the quality of care and save money through some of the changes you are proposing there.

Those are important parts of the Affordable Care Act that, together with others, will strengthen health care protections for the American people, including provisions that have already taken effect, including making sure that insurance companies can no longer discriminate against kids with asthma, diabetes, or other preexisting conditions by denying them coverage, including making sure that young people up to the age of 26 can stay on their parents' health care plans; including providing tax credits to hundreds of thousands of small businesses who can now afford to provide coverage to their patients; and including beginning and ultimately closing the prescription drug doughnut hole in Medicare that many seniors find themselves trapped in.

Those are some of the important improvements that have been made. So I believe that the fundamental question, the fundamental underlying question of today's hearing is, what is the best way to strengthen our health care system; and specifically, how do we keep the promise of Medicare and meet the challenges of Medicare, as the chairman has said?

One way, one approach, is to build upon the very important reforms that were enacted in the Affordable Care Act. The Medicare trustees have found that those measures will indeed reduce the per-capita costs for Medicare beneficiaries going forward, the increase in per-capita cost, that it will help bend the curve, and that it will, in fact, extend the solvency of Medicare. We need to build upon those approaches.

As we have heard in testimony before this committee, from Dr. Rivlin and others, the Affordable Care Act opens all sorts of new avenues to try and modernize the structure of Medicare, which we need to do. We need to change the incentive structure so that it rewards the quality of care, the value of care over the volume of care and the quantity of care. And Mr. Chairman, we agree that significant changes need to be made to modernize the system in this way.

The Independent Payment Advisory Board is simply one tool in the tool box for getting it done. It creates a back-stop or a fail-safe provision to ensure the continued solvency of Medicare if, and only

if, the Congress chooses not to act, to take other measures to build upon the kind of changes we saw in the Affordable Care Act.

And by the way, the IPAB is specifically prohibited by law from changing Medicare benefits. That prerogative is reserved to the Congress. Moreover, the latest CBO projections indicate that the rates of growth in spending per beneficiary are below the target rates of growth for fiscal years 2015 and 2021 set forth in the Affordable Care Act, and therefore CBO projects that under current law, the IPAB mechanism will not affect Medicare spending during the 2011 to 2021 period. So building on that approach is one way.

What is the other approach? The other approach is a path set forward in the Republican budget plan, a plan that will end the Medicare guarantee and will force Medicare beneficiaries into the private insurance market. That plan is a double whammy, a double whammy for Medicare beneficiaries for the following reasons: First, the Congressional Budget Office has determined that that plan will actually drive up overall health care costs. It changes the allocation of the burden, but it drives up overall health care costs. Why? Because providing that care in the private market is more expensive. And, in fact, if you look at the history of per-capita growth rates in the private market compared to per-capita growth rates in Medicare, Medicare has actually outperformed the private market. And therefore you are saying to those seniors, we are going to toss you into the private insurance market where you are going to face higher premiums and costs.

Why is it a double whammy? Because as you do that, you dramatically reduce the support for Medicare beneficiaries from the Federal Government. Dramatically. And as CBO has pointed out, by the year 2030, you essentially flip the burden from where it is today. Today the Medicare beneficiary, on average, picks up about 30 percent of the costs and the Medicare program picks up about 70 percent. By the year 2030, under the Republican plan, it is the reverse, because of the rising costs of care and the diminishing support from Medicare. Double whammy.

And I want to just really wrap up with this point, because we have heard it said that what the Republican plan offers Medicare beneficiaries is really the same as what Members of Congress get. The reason that is simply untrue is because Members of Congress, by law, have a certain percentage of their health care premiums supported by the Federal Government, by the taxpayer. In fact, under what is called the Fair Share Formula, that ranges from 72 to 75 percent, on average, the share that is picked up by the Federal Government.

Under the Republican planned future Medicare, we are going to be asking essentially Medicare beneficiaries to pick up themselves that cost, and the Federal Government will pick up only the remainder; so essentially, the flip of the deal that Members of Congress give themselves. That is unfair.

We have to make choices. We have said many times on this committee, to govern is to choose. We have lots of members on our side who are not wild about every aspect of IPAB, even in its back-stop role. But I think we are united, and I believe ultimately the American people are united, that that is a better approach—we have to fix the kinks as we go along—than the idea of ending the Medicare

guarantee and throwing that decision, not to experts who are confirmed by the United States Senate as a back-stop, but the people on the front line will be the insurance industry. Under the Republican plan, it is the insurance industry that fixes the benefits, frankly, actually in consultation with, what you guys say, "Federal bureaucrats." And they will set the premiums and they will choose; not the patients, at the end of the day.

So that is the choice. Mr. Chairman, thank you for holding this hearing. And I look forward to the testimony.

Chairman RYAN. Thank you.

[The prepared statement of Mr. Van Hollen follows:]

PREPARED STATEMENT OF HON. CHRIS VAN HOLLEN, RANKING MINORITY MEMBER, HOUSE COMMITTEE ON THE BUDGET

Thank you Mr. Chairman. I want to join Chairman Ryan in welcoming you, Madame Secretary, to the panel and to the other witnesses we are going to hear from later. And I want to commend you on two initiatives you've recently undertaken to help implement the Affordable Care Act. One is the Rules Guidelines you have recently released to govern the exchanges, which will open the door to millions more Americans being able to get affordable health care in the United States of America. The other, that received less attention, is your recently announced initiative to improve the coordination or care for individuals who are on both Medicaid and Medicare, called the dual eligibles.

It was you who pointed out using some of the innovative approaches in the Affordable Care Act, we can both improve the quality of care and save money through some of the changes you are proposing there. Those are important parts of the Affordable Care Act that together with others will help strengthen health care protections for the American people, including provisions that have already taken effect, including making sure insurance companies can no longer discriminate against kids with asthma, diabetes, or other preexisting conditions by denying them coverage, including making sure that young people up to the age of 26 can stay on their parents' health care plans, including providing tax credits to hundreds of thousands of small businesses who can now afford to provide coverage to their patients. And including beginning and ultimately closing the prescription drug donut hole in Medicare that many seniors find themselves trapped in. Those are some of the important improvements that have been made.

So I believe that the fundamental question, the fundamental underlying question of today's hearing is What is the best way to strengthen our health care system, and specifically, how do we keep the promise of Medicare and meet the challenges of Medicare as the chairman has said? One approach is to build upon the very important reforms that were enacted in the Affordable Care Act. The Medicare trustees have found that those measures will indeed reduce the per capita cost for Medicare beneficiaries going forward, the increase in per capita cost; that it will help bend the curve and that it will in fact extend the solvency of Medicare. We need to build upon those approaches. As we have heard in testimony before this committee from Dr. Rivlin and others, the Affordable Care Act opens all sorts of new avenues to try and modernize the structure of Medicare, which we need to do. We need to change the incentive structure so that it rewards the quality of care, the value of care, over the volume of care and the quantity of care. And Mr. Chairman, we agree that significant changes need to be made to modernize the system in that way.

The Independent Payment Advisory Board is simply one tool in the toolbox for getting it done. It creates a backstop, or a failsafe provision to ensure the continued solvency of Medicare if, and only if, the Congress chooses not to act to take other measures to build upon the kind of changes we saw in the Affordable Care Act. And by the way, the IPAB is specifically, specifically prohibited by law from changing Medicare benefits. That prerogative is reserved to the Congress. Moreover, the latest CBO projections indicate that the rates of growth in spending for beneficiary are below the target rates of growth for fiscal years 2015 and 2021 set forth in the Affordable Care Act and therefore CBO projects that under current law, the IPAB mechanism will not affect Medicare spending during the 2011 to 2021 period.

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Chairman RYAN. Madam Secretary, the floor is yours.

STATEMENT OF KATHLEEN SEBELIUS, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SEBELIUS. Thank you, Mr. Chairman. Chairman Ryan, Ranking Member Van Hollen, members of the committee, I appreciate you inviting me here today to discuss how the Affordable Care Act is strengthening Medicare for seniors today and tomorrow. My written testimony provides more detail, but I want to quickly highlight some of the steps we are taking as part of the health care law to fill the gaps in Medicare coverage, to improve care and make the program more sustainable for the future, while preserving its guarantees for seniors and for people with disabilities.

When Medicare became law in 1965 it served as a national promise that seniors wouldn't go broke because of a hospital bill. In 2006 the Medicare program added coverage for prescription drugs, which makes up a growing share of beneficiaries' health care costs. But we know that too many seniors still struggle to afford their medications, and that is why the Affordable Care Act provided relief to 4 million beneficiaries who fall, year in and year out, into the Medicare Part D doughnut hole with, in 2010, a one-time, tax-free check for $250. And some of the beneficiaries who have written

to me say they basically took that check and went right to the drug store to help pay a part of their bill. And this year, because of the Affordable Care Act, those same beneficiaries are getting a 50 percent discount on covered name brand drugs. By 2020 that gap closes completely.

We also know that many seniors were going without the preventive care that can help actually prevent illness before it occurs, lowering costs and saving lives. And in some cases, they were doing that because of expensive co-pays, and that doesn't make a lot of sense. So beginning this year, the law allows Medicare beneficiaries to receive recommended preventive services like screenings for colon and breast cancer, as well as an annual wellness visit, without paying a co-pay or deductible. It is the right thing to do and it is the smart thing to do because it helps us catch small health problems before they turn into big ones.

The law is also helping to improve the quality and safety of care for people with Medicare. Now, we know that there are model hospitals across the country that have adopted best practices to dramatically increase the quality of care. In fact, for every common medical error, we have examples of health systems that have significantly reduced, even eliminated, them. And there is no reason why all Medicare beneficiaries shouldn't enjoy that same high quality of care wherever they receive it. And that is why the Affordable Care Act provides unprecedented support to help these best practices spread.

In March, we launched the Partnership for Patients, an historic partnership with employers, unions, hospital leaders, physicians, nurses, pharmacists and patients' advocates to reduce harm and error in our Nation's hospitals. Last week we were able to announce that more than 2,000 hospitals across the country have already signed up and are taking steps to improve care aimed at two very important goals: reducing preventable readmissions and reducing hospital-acquired conditions.

Under the law, we have also established the first of its kind Medicare/Medicaid Coordination Office that Congressman Van Hollen referred to. The office is working with States to improve care for beneficiaries who were enrolled in both Medicare and Medicaid and often receive fragmented or duplicative care as a result. And through the new Medicare and Medicaid Innovation Center created by the law, we are testing a wide range of additional models for increasing the quality of care, from strategies for helping seniors manage their chronic conditions, to new models in which hospitals and doctors who help keep their patients healthy and out of the hospital can share in the cost of savings they create. Together, these reforms are dramatically strengthening Medicare today for seniors and Americans with disabilities.

But we also have the responsibility to preserve the promise of Medicare for future generations, and we can't do that if costs continue to rise unchecked. Because doing care the right way often costs less than doing it the wrong way, many of the law's reforms are aimed at improving care and reducing Medicare costs. For example, the Partnership for Patients alone, with those two pretty tangible goals, will save Medicare as much as $50 billion over the next 10 years by reducing errors that lead to unnecessary care.

But the law doesn't stop there. It also contains important new tools to help stamp out waste, fraud, and abuse in Medicare. For fiscal year 2010, our anti-fraud efforts returned a record $4 billion to taxpayers, and these tools in the Affordable Care Act help us to build on that progress. The Medicare trustees estimate that these reforms in the Affordable Care Act have already extended the solvency of the trust fund until 2024. Without these reforms the trust fund would have been insolvent just 5 years from now.

But when it comes to Medicare's future, we can't take any chances, and that is why the law also creates the Independent Payment Advisory Board, or IPAB, as a back-stop, a fail-safe to ensure Medicare remains solvent for years to come. As you know, the IPAB is made up of 15 health experts, including doctors, other health care professionals, employers, economists and consumer representatives. Members are recommended by Congress, appointed by the President, and confirmed by the Senate. And each year, the Board is charged with recommending improvements to Medicare. The recommendations must improve care and help control costs.

For example, the Board can recommend additional ways for Medicare to reduce medical errors and crack down on waste and fraud. And contrary to what some have suggested, IPAB will not ration care or shift costs to seniors. In fact, the Board is specifically forbidden by law from making any recommendations that would ration care, reduce benefits, raise premiums, or raise cost-sharing or alter eligibility for Medicare. It leaves all final decisions in the hands of Congress.

If Medicare spending begins to threaten the program's future, IPAB will make recommendations to create the necessary savings without shifting the cost of care to seniors and those with disabilities. But it is up to Congress to decide whether to accept the recommendations, or to come up with recommendations of its own to put Medicare spending on a stable, sustainable path. In other words, the IPAB recommendations are only implemented when excessive spending growth is not addressed and no other actions are being taken to bring spending in line.

Now, the nonpartisan Congressional Budget Office and the independent Medicare actuary both predict that the IPAB is unlikely to be necessary anytime soon, thanks to the work we are already doing to slow down rising costs. But we can't know about the future. And that is why experts across the country, including independent economists and the Congressional Budget Office, believe that IPAB is a needed safeguard, and we agree. We believe that the best way to strengthen Medicare for today and tomorrow is to fill the gaps in coverage, to crack down on waste and fraud, to bring down the cost of improving care. And that is what we are working to do, given the new tools in the health care law.

Over the last 16 months, our Department has focused on working with Congress and our partners across the country to implement the new law quickly and effectively. And in the coming months I look forward to working with all of you to continue those efforts and to make sure that Americans can take full advantage of all that the new law has to offer.

Thank you again, Mr. Chairman. And I look forward to our conversation.

Chairman RYAN. Thank you.
[The prepared statement of Secretary Sebelius follows:]

PREPARED STATEMENT OF HON. KATHLEEN SEBELIUS, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Ryan, Ranking Member Van Hollen, and Members of the Committee, thank you for the opportunity to discuss our Department's implementation of the Affordable Care Act. Millions of Americans across the country are already benefiting from this law, including more than 100 million people currently enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Over the past 16 months, we have worked closely with doctors, nurses, other health care providers, consumer and patient advocates, employers, Governors, State Insurance Commissioners, health plans, and interested citizens to deliver many of the law's key benefits to the American people, including Medicare beneficiaries. These benefits include improving seniors' access to affordable, life-saving medications; offering new preventive care benefits for Medicare beneficiaries; improving care coordination for beneficiaries eligible for both Medicare and Medicaid; and implementing new tools to fight fraud and return money to the Medicare Trust Funds and Treasury.

I am proud to say that we have met deadlines, established strong working partnerships, and begun laying the groundwork for reforms that will have lasting effects in the years to come. This law means real improvements for the care of Medicare beneficiaries now, and a stronger and more fiscally sound Medicare program in the future.

Making Medicare sustainable is not about cutting program benefits or shifting costs onto seniors. Sustainability for Medicare requires fundamental changes to the way that health care is delivered—changes that will lead to better health, better care, and lower costs. The Affordable Care Act includes new policies and authorities that will make critically needed delivery system reforms while preserving Medicare's guarantees for seniors and people with disabilities.

IMPROVED VALUE FOR SENIORS AND PEOPLE WITH DISABILITIES

Thanks to the Affordable Care Act, Medicare beneficiaries will enjoy better quality care, better access to care, and a more innovative care delivery system that will help to improve outcomes and reduce cost. People with Medicare have already experienced improved benefits that help to keep them healthy and make prescription drugs more affordable. The important changes called for in the Affordable Care Act will also produce savings for taxpayers and extend the solvency of the Medicare Trust Fund. Medicare's long-term outlook is improved as a result of the development of new systems of health care delivery that will improve health care outcomes and cost efficiency, and provide more effective tools to reduce waste and fraud. These measures will also help people with Medicare by slowing the growth of their monthly premiums, and by keeping their copayments and deductibles lower than they would have been under previous law.

Here are just a few examples:

• Improving Medicare beneficiaries' access to life-saving medicines: As a result of new provisions in the Affordable Care Act, people with Medicare have already received immediate relief from the cost of their prescription medications. Nearly 4 million beneficiaries received a one-time, tax-free check for $250 after reaching the Part D coverage gap, or "donut hole," during 2010. In 2011, this benefit has improved dramatically. Beneficiaries now automatically receive a 50 percent discount on covered brand-name drugs in the coverage gap. Among beneficiaries who have reached the coverage gap, the average beneficiary has saved $545, for total savings of more than $260 million in the first five months this year. Further, 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.

• Increased access to preventive care: Thanks to the Affordable Care Act, people with Medicare now 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 that provides a focus on preventive care. As of June 10, about 5.5 million people with Medicare have accessed one or more of these preventive measures. 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 more 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.

• High quality Medicare Advantage benefits: This year, HHS has improved its oversight and management of the Medicare Advantage (MA) program. The results for the 2011 plan year show that these efforts are paying off: seniors and people living with disabilities have clearer plan choices that, on average, offer improved protections and stable benefits at lower premiums. Contrary to predictions of enrollment decline, 2011 MA enrollment is up six percent and average premiums are down six 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 traditional Medicare. As part of the Administration's national strategy for implementing quality improvement in health care, CMS is also working to create new incentives for all MA plans to improve the care they offer to Medicare beneficiaries. Beginning in 2012, CMS will implement a demonstration that builds on the quality bonus payments authorized in the Affordable Care Act by providing stronger incentives for plans to improve their performance, thereby accelerating quality improvements. These enhanced incentives will help provide a smooth transition as MA payments are gradually aligned more closely with costs in the Medicare fee-for-service program.

• 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.

• 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. 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.[1] 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.[2] 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 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.[3] Proper attention to care transitions, coordination, outreach, and patient education and support could all 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

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[1] 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.*

[2] Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, November 2010, *http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.*

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

partnering with community-based organizations to improve transitional care processes. Per the Affordable Care Act, the readmission rate information for all patients in each hospital participating in the program will publicly available online.

BETTER CARE: A PARTNERSHIP WITH STATES

The Affordable Care Act is beginning to improve the way care is delivered to Medicare beneficiaries. Too often, health care takes place in disconnected fragments. Instead, we should make it possible for new levels of coordination and cooperation to take place among the people and the entities that provide health care, in order to smooth the journeys of patients and families—especially those coping with chronic illness—through their care over time and in different places.

For example, coordination is critically needed in providing care to more than 9 million beneficiaries who are eligible for both Medicare and Medicaid, also known as dual eligibles. The Affordable Care Act established a Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, to improve coordination of the care provided to these beneficiaries. This population is among the most vulnerable and chronically ill beneficiaries: though they represent only 15 percent of Medicaid enrollees, they account for 39 percent of Medicaid expenditures. Similarly, they are 16 percent of Medicare enrollees but account for 27 percent of Medicare expenditures. Dual eligibles must navigate two separate systems: Medicare for coverage of basic health care services, and Medicaid for coverage of long-term care supports and services and help with Medicare premiums and cost-sharing.

The Medicare-Medicaid Coordination Office is working to better streamline care for dual eligibles by improving alignment between the two programs, sharing data that is critical to States' ability to manage care for these individuals, and supporting States' innovative approaches to coordinating care for dual eligibles. The office has been hard at work. Some of its initiatives include:

• On May 11, 2011, the Medicare-Medicaid Coordination Office launched the Alignment Initiative, an effort to more effectively integrate benefits under the Medicare and Medicaid programs. Better alignment of the two programs can reduce costs by improving health outcomes and more effectively and efficiently coordinating care.

• Also on May 11, the Office announced a new process to provide States access to Medicare data to support care coordination for individuals enrolled in both Medicare and Medicaid. The ability to access both sets of information on beneficiaries covered by both programs enables States to better analyze, understand, and coordinate a person's experience.

• Partnering with the Center for Medicare and Medicaid Innovation, the Office has awarded contracts of up to $1 million each to 15 States to design person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services for Medicare-Medicaid enrollees.[4] The overall goal of this contracting opportunity is to identify delivery system and financial models that can be rapidly tested and, upon successful demonstration, replicated in other States.

• On July 8, 2011, HHS announced new opportunities for partnering with States to improve quality and costs for Medicare-Medicaid beneficiaries. Specifically, we announced a demonstration program to test two new financial models designed to help States improve quality and share in the lower costs that result from better coordinating care for individuals enrolled in Medicare and Medicaid; a demonstration program to help States improve the quality of care for people in nursing homes by providing these individuals with the treatment they need without having to unnecessarily go to a hospital; and a technical resource center available to help them improve care for high-need high-cost beneficiaries.

PROGRAM INTEGRITY

As we move forward with new and exciting benefits and care models, we are redoubling our efforts to minimize waste, fraud, and abuse in Federal health care programs. This Administration has put an unprecedented focus on reducing fraud and improper payments, and is making progress towards that end. A greater focus on program integrity is integral to the success of Medicare reform. In 2010, our collective efforts returned over $4 billion in health care fraud resources to the Medicare Trust Fund, victim programs, and others. The Affordable Care Act offers additional front-end protections to keep those who commit fraud out of Federal health care programs, as well as new tools for deterring wasteful and fiscally abusive practices, promptly identifying and addressing fraudulent payment issues, and ensuring the

[4] *http://www.cms.gov/medicare-medicaid-coordination/04—StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage*

integrity of our programs. Recently, CMS consolidated Medicare and Medicaid program integrity efforts into one office, the Center for Program Integrity.

This organizational change, coupled with the new tools provided by the Affordable Care Act, enhances CMS's ability to improve its program integrity capabilities and jointly develop Medicare, Medicaid and CHIP anti-fraud and abuse policies. For example, many Affordable Care Act provisions, such as enhanced screening requirements for new providers and suppliers, apply across the programs. In addition, oversight controls such as authority for temporary enrollment moratoria and authority for a temporary withhold on payment of claims for new durable medical equipment suppliers based on risk, will allow us to better focus our resources on addressing the areas of greatest risk and highest dollar impact.

Further, on July 1, 2011, CMS implemented a new predictive modeling technology developed with private industry experts to fight Medicare fraud. Similar to the technology used by credit card companies, predictive modeling will help identify fraudulent Medicare claims prior to payment on a nationwide basis so we can begin to take action to stop fraudulent claims early on. This initiative builds on the new anti-fraud tools and resources provided by the Affordable Care Act. Together, these tools are helping us move beyond "pay and chase" recovery operations to an approach that prevents fraud and abuse.

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 Department of Health and Human Services' Office of Inspector General to collaborate and streamline our efforts to prevent, identify, and prosecute health care fraud.

INDEPENDENT PAYMENT ADVISORY BOARD

All of this work reflects this Administration's vision for improving the health of seniors and securing Medicare finances for the future. By reducing the underlying costs of the health care system and by improving the care our seniors receive, we can continue to serve today's beneficiaries while preparing for tomorrow's.

We also know that the future of Medicare requires continued vigilance and careful oversight, which is why we support the creation of a backstop mechanism to ensure Medicare remains solvent for years to come. The Independent Payment Advisory Board (IPAB) builds on the commitment we have made to our seniors' health.

The IPAB will consist of 15 health experts, including health care providers, patient advocates, employers, and experts in health economics. The Affordable Care Act provides for consultation between the President and Congressional leadership in appointing members of the Board, and appointments are subject to the advice and consent of the Senate. Their work will be objective and transparent.

The Board's primary responsibility will be to recommend improvements to Medicare. Recommendations of the IPAB will focus on ways to improve health care while lowering the growth in Medicare spending. For example, the Board could recommend approaches that would build on and strengthen the initiatives mentioned above, from reducing medical errors, to strengthening prevention and improving care coordination, or targeting waste and fraud.

At the same time, the law contains important limitations on what the Board can recommend. The statute is very clear: the IPAB cannot make recommendations that ration care, raise beneficiary premiums or cost-sharing, reduce benefits, or change eligibility for Medicare. The IPAB cannot eliminate benefits or decide what care Medicare beneficiaries can receive. Given the long list of additional considerations the statute imposes on the Board, we expect the Board will focus on ways to find efficiencies in the payment systems and align provider incentives to drive down costs without affecting our seniors' access to the care and treatment they need. The Board's recommendations are also just that—recommendations—unless Congress fails to act. Congress still has the authority to make final decisions.

Starting in 2014, Medicare will have specific benchmarks for per capita spending increases. These benchmarks will initially be set at the average of the increases in CPI and CPI-Medical. Beginning in 2020, the benchmark will be set at the rate of growth of GDP per capita + 1 percentage point. Given these benchmarks, the Medicare Actuary predicts that the IPAB will be needed mainly as a backstop. Through the Affordable Care Act and our program integrity efforts, we have already substantially reduced the rate of growth in projected Medicare spending. The Office of the Actuary predicts that per beneficiary spending in the Medicare program will grow at a rate below the GDP+1 percentage point benchmark throughout the 75 year projection period. Indeed, the Office of the Actuary predicts that over the next decade per beneficiary Medicare spending will grow at about the same rate as GDP per capita, including an allowance to raise future physician payments to avoid the cuts

mandated by the Sustainable Growth Rate formula. That would be a substantially slower rate of growth in expenditures per beneficiary, over a 10 year period, than has ever before been seen in the Medicare program. In addition, the current Medicare spending baseline prepared by the Congressional Budget Office assumes that Medicare spending growth will not exceed the benchmark amounts over the next 10 years. Of course, predictions are just that—predictions—and predictions are not always certain. Health care spending patterns—or the rate of growth in the benchmarks—could change. The IPAB backstop means that if Medicare spending growth does exceed growth in the benchmarks, the IPAB will make specific recommendations, and Congress will then have the opportunity to take action. If Congress rejects IPAB recommendations, they will replace them with reforms that bring Medicare spending growth to or below the benchmark—achieving the same savings. The Board's recommendations will only go into effect if Congress accepts them, or if Congress fails to act. In other words, the IPAB recommendations are only implemented when excessive spending growth is not addressed, and other actions being taken are insufficient to bring spending to levels at or below the benchmark.

Experts across the country, including independent economists and the Congressional Budget Office, believe the IPAB is a needed safeguard. We agree, which is why the President's deficit reduction framework strengthens the Board. This will ensure that we protect Medicare's future without resorting to radical benefit cuts or cost-shifting to seniors and people with disabilities.

CONCLUSION

The accomplishments listed above are just some of the many benefits that the Affordable Care Act has provided. The Affordable Care Act has already had a positive impact on Medicare beneficiaries, as well as on the millions more who now have greater options and protections in their private health insurance. Our Department has worked hard to implement the many new programs and authorities that the Act has provided us. We take very seriously our responsibility to improve access, quality, and efficiency of care for all our Medicare beneficiaries, while protecting the long-term fiscal integrity of the Medicare program.

Chairman RYAN. As I mentioned in my opening, I quoted the President, which I thought was pretty much head-on with his remarks about Medicare. The trustees, your chief actuary projects the trust fund goes bankrupt in 2024. CBO tells us it is in 9 years.

Do you agree with the President and Medicare's chief actuary that the status quo as we know it, the traditional fee-for-service system is unsustainable and will soon fail to deliver the promise of health and retirement security for seniors that we all depend on?

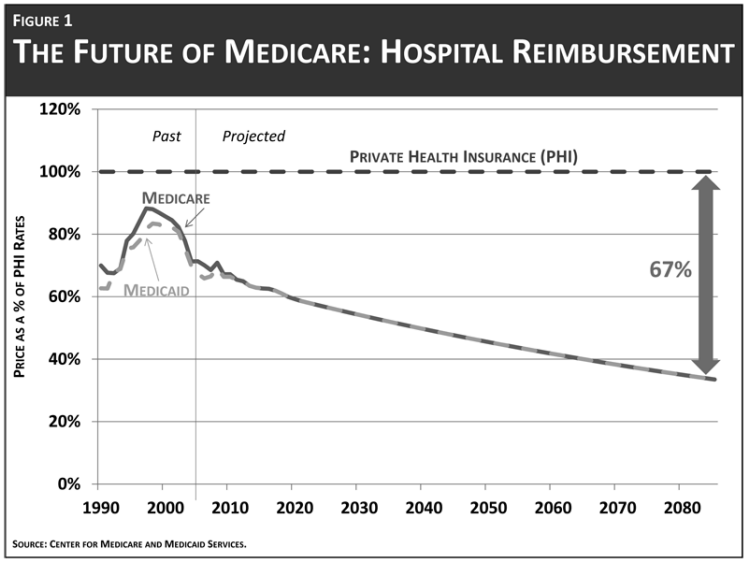
Secretary SEBELIUS. Well, Mr. Chairman, I believe that the fee-for-service system has incentives in all the wrong places, so we are often paying for care that actually delivers very poor health results. And in fact, in many cases, if people are sicker, stay in the hospital longer, acquire more infections, are readmitted more frequently, that hospital makes additional money, as opposed to preventive aggressive home-based, patient-centered care, which often is not only more desirable by the patient and doctor, but actually lowers the cost.

So the Affordable Care Act for the first time gives Medicare not only the tools but the direction to actually align the incentives and, I think, the payment strategies.

Chairman RYAN. Okay. So I think on the premise of that we would agree, which is the current system is unsustainable and has all the wrong incentives, which is part of the reason why it is driving it toward bankruptcy.

Secretary SEBELIUS. I would say that the current fee-for-service system, yes, is unsustainable.

Chairman RYAN. So if you could bring up chart one, please.



So here is the question we have. I have got basically three questions. And this is, it is basically, you know, how best to solve this problem. According to your chief actuary, providers who are reimbursed through Medicare receive about 80 percent of what a private plan offers. And as we all know, what inevitably happens is, if a provider loses money on a Medicare patient, then they will overcharge the private payer to make up the difference. And that is putting upward pressure on prices, on health care costs. Under the health law, the Affordable Care Act, this falls from 80 percent to 48 percent by 2022, and to 33 percent by 2050.

Hospitals suffer the same fate. This is the hospital reimbursement rate curve under the new health care law. A 67 percent drop in prices relative to what private plans pay over the course of the window. So we are already paying them, providers, through Medicare, far less than they get otherwise. In most cases we are paying less than they actually—the cost of the care.

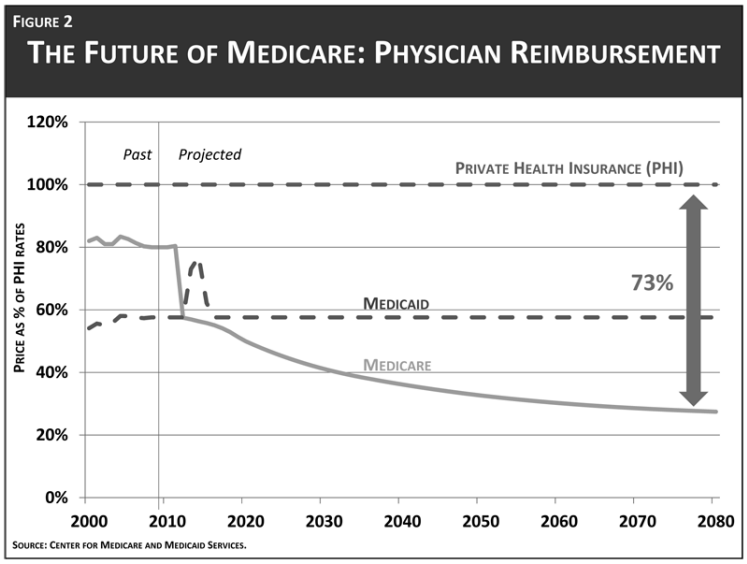
And so basically, I have three questions. Do you agree with the chief actuary's findings that cutting payments to providers does have an effect on providers? Because here is what he says. He is saying that by the year 2050, 40 percent of hospitals, skilled nursing facilities, and home health agencies will have negative margins. In other words, they will go bankrupt. So that means they will leave the business of providing Medicare services to Medicare beneficiaries. Do you agree that cutting payments to providers has an effect on providers in such a way?

Secretary SEBELIUS. Mr. Chairman, I do believe that certainly cutting payment has an impact. What I know is that Medicare cost trends are actually significantly, I would say, better than the private sector, growing at about 4.9 percent, as opposed to the private sector growth of about 7.2 percent over the last 10 years. And I do believe that Medicare has the opportunity to actually change the cost trends by improving the underlying costs of delivering health

care, as opposed to—I would suggest that the House Republican plan just shifts those costs onto seniors and those with disabilities and does not address the underlying costs at all. I think improving care and lowering costs makes a lot more sense than just shifting costs.

Chairman RYAN. Well, okay. So this is the hospital chart which shows, under the Affordable Care Act, reimbursements to hospitals goes down precipitously.

Go to chart two if you can.



That is the physician chart which shows Medicare and Medicaid obviously goes down precipitously under what private plans pay. So obviously, if we underpay them it is going to save more money. The question is, if we keep underpaying them at this pace, will they keep delivering the benefit? I mean, so our issue here is if there are fewer providers participating in Medicare, because their payments are going down so far below their cost—we have 10,000 baby boomers retiring every day. Do you not agree that if we underpay them, that they will just stop seeing beneficiaries?

Secretary SEBELIUS. Mr. Chairman, I think that assumption is that nothing changes in care. Nothing changes in the care trajectory, that we keep paying at the same—not only rates, but keep paying for the same kinds of services. So if you assume that care delivery doesn't change at all, that we keep paying for good care the same as bad care, that we don't have any changes in underlying care, that we don't coordinate care, that we don't have more home-based patient-based care, that we keep the churning of one out of every five Medicare patients going in and out of the hospital, whether or not they have seen a health care provider or not, that trend line is probably accurate.

I would suggest that what the Affordable Care Act does, and what we have begun to do, I think pretty successfully in these early days with the innovation center and the very enthusiastic

support of a lot of health care providers across the country, is look at where the best practices are, where the hospital systems are and the provider groups who have actually delivered very high-quality care, well below the trend line, and capture that; and then reach out to others to try and accelerate that change, and use the enormous payment levers of the Medicare system to do just that, to drive best practices.

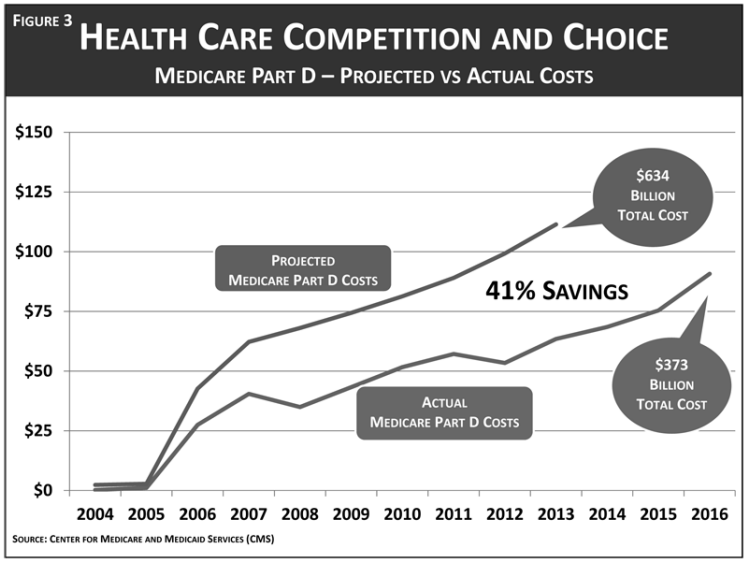
Chairman RYAN. So we are right now looking at a law that will pay providers 80 cents on the dollar, then 66 cents on the dollar in this decade, going down to 33 cents on the dollar. So you are saying that we will be able to sort of mastermind how to pay for this care at those low rates and they will still provide these services? This is where I don't understand this.

Ultimately, don't you believe that there is going to be a time where if you are going to so dramatically underpay for a service to a provider that they would provide a beneficiary, that they will just stop providing that service? I mean isn't that effectively rationing, in of and of itself? If you don't pay the providers anything close to what it costs to provide the service, won't they just stop providing the service?

Secretary SEBELIUS. Well, Mr. Chairman, again, I would suggest that what is going to occur, and is occurring across the country, is a different kind of service being provided, a different strategy around health care services, and one that actually suggests that doctors and hospitals, through mechanisms like the Accountable Care Organization, actually group together around quality-care delivery and share in the savings that they achieve. We have heard from very enthusiastic participants around that strategy.

So I think if you capture the status quo and say you just drive that into the future and nothing ever changes, this is probably an accurate chart. But I don't believe that that is sustainable. I also don't believe, Mr. Chairman, that just taking those cost trends, shifting the burden of costs onto seniors and those with disabilities, which the plan that has been passed by the House of Representatives does, addresses this at all. It just means that more of those costs are going to be paid by seniors and those with disabilities. It doesn't bring more doctors. It doesn't change the underlying costs. It doesn't deliver better care. It means that fewer and fewer seniors out of their own pocket are going to be able to afford the care they need.

Chairman RYAN. Can you bring up chart three?



Okay. So this chart shows you what we thought prescription drug law was going to cost originally. Actually, the CMS actuary estimated it was going to be about a $700 billion, 10-year program. CBO, a $400 billion program. It came in 41 percent below those cost projections, 41 percent below the CBO projections, which were $400 billion, versus the CMS, $700 billion projection.

And so I want to ask you basically this. Do you, if you had to do it over again, because at the time there was a debate between Republicans and Democrats about how to do the drug program. The Republican view prevailed at that time, which was to have Medicare certify private plans to offer drug benefits to seniors and each year they get to choose among competing plans for their benefit. And that active choice of competition, according to your actuary, accounts for 85 percent of the cost reductions or the savings from the projection. If you had to do it all over again, would you scrap the Part D program the way it is designed today and would you have gone with the original point of view that it should just be one program run by Medicare and not one of competing plans?

Secretary SEBELIUS. Mr. Chairman, I don't know that I could answer that question. I think there were a few fatal flaws in Part D that I certainly would go back and change. One was the design of the program so that the seniors who got the most prescriptions fell into a coverage gap; and, secondly, it wasn't paid for. So one of the reasons that Medicare is becoming less solvent is that we have a huge unfunded liability in Part D.

Chairman RYAN. But the delivery system, would you have stuck with multiple plans that people can choose from, or would you have sided with the position at the time of your party that we should not have that, we should just have a one-size-fits-all, only Medicare provides the drug benefit.

Secretary SEBELIUS. As I say, I think there are some fatal flaws that have been corrected. I do think that the drug program is an

essential benefit that many, many seniors rely on. I can't tell you the cost estimates of one versus many. I do think Medicare still pays for drugs at a higher price than anyone on Earth, and as a Governor who used to run a program where I negotiated for drug prices, I can tell you that they are still overpaying for drugs.

Chairman RYAN. Let me ask it this way. Should seniors be given a choice of plans to choose from to get their drug benefit?

Secretary SEBELIUS. I think that is a great idea. And seniors are given a choice of Medicare programs now with Medicare Advantage, and many have also some fee-for-service plans along with traditional Medicare. What we know, though, is that Medicare Advantage, the private market strategy, is still well above the fee-for-service strategy, and no beneficial health results as a result.

Chairman RYAN. Okay. I don't want to keep wasting time on this. But you agree with the idea that seniors ought to have plans from which to choose from for their benefits; is that correct?

Secretary SEBELIUS. You tell me what we are looking at and what costs are—I mean it is impossible to——

Chairman RYAN. I have been asking you about Part D the whole time. Should they have a choice of plans for their drug benefit?

Secretary SEBELIUS. As opposed to what?

Chairman RYAN. As opposed to the other idea of not having a choice of plans.

Secretary SEBELIUS. If it is 30 percent cheaper with the negotiated rate, probably that doesn't make sense. It is a choice. I mean, having drug benefits is critical and I would like to get seniors the drug benefit at the best possible cost.

Chairman RYAN. Okay. Here is the point we are trying to get at here. The health care law, the Affordable Care Act, ends the Medicare guarantee. It ends Medicare as we know it. It takes a half a trillion from Medicare to spend on the Affordable Care Act. It puts a cap on Medicare. And this is the first time we have actually capped an entitlement.

Now, nobody is arguing against capping spending around here. The only difference is, this law empowers the IPAB with the unilateral power to decide how to live underneath that cap. And where we have an issue, you mentioned affordable care organizations. There isn't a Wisconsin provider that is willing to sign up for this. The ACOs. What our concern is, if we invest all of the power and the funding decisions with a Board of 15 people whose decisions go into law, don't even go through Congress, is that the best way to save this entitlement and to restrain spending?

We believe there is a better way, and we believe giving seniors the choice, like we did with Part D, is a better way, because what it does at the end of the day is it shows providers if you want to succeed, if you want to have business, you have got to outcompete other providers for that beneficiary's business. So the nucleus of the program we are trying to take is the patient, the beneficiary, not the IPAB. And there is the big difference at the end of the day.

We really believe, because of evidence and reality, that giving seniors more choices, more providers, doctors, hospitals, insurance companies compete against each other for that beneficiary's business, that works.

More importantly, you talk about what this would do to future seniors. We think we should give more money to low-income people, more money to sick people than to wealthy people, in the future of Medicare. And if we do it in a way like we are proposing, you don't have to do all of this to the current population. You don't have to have IPAB start their indiscriminate price controlling in 2013, you don't have to do any of that. You don't have to affect benefits of people above 55, and we can cash flow and borrow the money to cash flow that generation if we reform our generation, those of us under 54. And the way in we which we think we ought to do that, more money for the poor, more money for the sick and the middle-income and less money for the wealthy. It is an idea that used to have bipartisan support. It is an idea that came out of the Clinton 1999 Bipartisan Commission to save Medicare. It is a very good and legitimate debate to debate about growth rates and how you grow a payment and should it be GDP or GDP minus this or that. That is a very fair debate.

But at the end the day, where I think we have a disagreement is we don't think we should invest all of the power and money decisions into the hands of 15 people who aren't even elected, versus giving seniors the ultimate decision in controlling how their health care is to be delivered. Because if we just simply give 15 people the ability to unilaterally underpay providers, and we see where this is headed, what is going to end up happening is providers are just going to drop Medicare. I don't know what you call that, but it is rationing under a different word. Because if you say to a provider, we are not going to pay you anything close to what it costs to provide that service, they are not going to provide that service.

Secretary SEBELIUS. Well, Mr. Chairman, first of all, IPAB, as you know, in the statute, doesn't come into effect unless Congress has not taken action. So Congress is in the driver's seat. Day one, IPAB makes recommendations if the spending trends are on target.

Chairman RYAN. What is the threshold? It is a supermajority vote to prevent that, though, correct?

Secretary SEBELIUS. Only if Congress has not preceded IPAB. I am suggesting that if Congress is actually paying attention to the bottom line of Medicare, IPAB is irrelevant coming up with good strategy suggestions, and it never triggers in. That is step one.

I also would suggest, Mr. Chairman, that, you know, when I think about Medicare, I actually start with my dad who was in the Congress in 1965, sat on the Energy and Commerce Committee, helped to write the law. He turned 90 in March. And I can tell you he is a happy beneficiary, relies on those services, but really doesn't have the capital right now. If he were paying 51 to 70 percent of his costs, it starts at 61 to 70 percent of his cost, that is not flexible income that he would have available right now.

Third, I think that the notion of moving Medicare from guaranteed benefits, which is what we have said to seniors and those with disabilities, you will have a benefit package that you can rely on into the future; when you get sick you will not go bankrupt. Turning that over to private insurers and to an unelected group of Federal employees who design the benefit package and determine which benefits seniors will and will not get, I am not sure keeps the promise that we made.

I am all for looking at strategies to reduce costs. And I would suggest that we have really never done that seriously until the Affordable Care Act. We have never had the tools and particularly the tools to look at the underlying costs. Not just, you know, trimming off the top of providers, but really reengineering the delivery of health care. And most, a good number of health care providers who I visit across the country, say not only is it achievable, it is essential, and they are well on their way to doing just that.

Chairman RYAN. Well, I want to be—I want to wrap it up because I want to get to Mr. Van Hollen and the rest. I have been on Ways and Means for 12 years, on the Health Subcommittee. I have watched us try to reengineer Medicare over and over and over, from Republicans to Democrats. It never ends up working because it is kind of a fatal conceit. We sit in Washington and we think we can figure out how to micromanage 17 percent of our economy and make this all work. And all we end up doing is artificial price controls across the board. That was what the 1997 budget agreement did. And we had all these providers going out of business. So we put the money back. I don't see how this movie isn't repeating itself.

Secretary SEBELIUS. Well, if Congress can't figure it out, private insurers are going to then figure out how to——

Chairman RYAN. So we already have private insurers delivering comprehensive Medicare benefits. They have shown that they will do it cheaper, less than we expected. We already have private insurers providing Medigap, providing Medicare Advantage, providing Part D. Actually you contract out with private insurers to do part A. And so that is something we have already had experience with.

What we also have experience with is if we simply underpay providers what their costs are, they stop providing. That we have experience with as well. And so I would just simply say at the end of the day, we have a difference of opinion on how best to achieve this.

My mom is on Medicare. Your dad is on Medicare. They have already organized their lives around this program as it is currently designed. Let's leave that alone. Our point is, don't change for that for them. IPAB does. We are saying don't do that. But in order to cash flow this commitment that they have already organized their lives around, which we should, you have got to fix it for the next generation, and we just have a difference of opinion on how best to do that.

And with that, I will yield to Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Mr. Chairman and Madam Secretary, thank you for your testimony.

I want to pick up on a couple of lines of questioning that the chairman began, especially as they relate to cost shifting, because that is exactly what the Affordable Care Act addresses in many ways. When you have tens of millions of Americans with no health insurance whatsoever, and they show up at the hospital as their primary care provider, guess who pays? Guess who pays? Taxpayers pay. And consumers pay through cost shifting.

Now, we have heard from the chairman about the fact that Medicare actually gets a better deal in terms of the amount of payment

to providers, and that is reflected in part in the fact that Medicare's per-capita growth rates have been less than in the private sector. That is because they are able to use their bargaining power.

What you are seeing with the Affordable Care Act are people who have no health insurance, not a penny. That was cost shifting going on. We were all paying in a big way. And by creating an exchange that tens of millions of Americans can participate in now and get their preventative health care, it means they are not showing up in the hospital. So it is not only good for the health of those individuals and their families, but it is good for the pocketbooks of the rest of America because they were paying zero to the doctors and zero to the hospitals.

Now let's talk about another piece of cost shifting, because, you know, obviously, if you pay the doctor zero, you are going to shift costs. Well, if you shift costs, if you shift costs the way the Republican plan does, you are not saving a penny to the system. You are just moving those costs on to seniors.

I have right here the April 5, 2011, CBO analysis of the Republican budget plan. It says right here that under the proposal, most beneficiaries who receive premium support payments would pay more for their health care than if they participated in traditional Medicare under either of CBO's long-term scenarios. CBO estimated that in 2030 a typical 65-year old would pay 68 percent of the benchmark under the proposal, compared with 25 percent under the extended baseline scenario, and 30 percent under the alternative fiscal scenario. I would point out again to my colleagues that that is the flip of what Members of Congress get in terms of support, so-called premium support from all points.

Let me just if I could get through this, and I will be happy to answer your question. So that is the exact flip. That is cost shifting. Doesn't save a penny, and it actually reduces the amount of support.

Now, I want, Madam Secretary, you to expand upon another point here which, as the chairman mentioned, we already have some private options, private insurance options within the Medicare program. It is called Medicare Advantage. It is called Medicare Part C. And the difference between the current system and what the Republican budget proposes is we allow the Medicare beneficiaries to choose whether they want to go into Part C or whether they want to stay under traditional Medicare. The Republican plan says no more choice. You are forced into the private plans. Now, the chairman mentioned what he described as the benefits of this compensation.

Madam Secretary, could you tell us what the rate that the Medicare program was reimbursing the so-called more efficient Medicare Advantage plans, compared to the traditional plans before the Affordable Care Act?

Secretary SEBELIUS. Yes. Congressman, Medicare Advantage plans were being paid at about 113 percent of fee-for-service. And what the Affordable Care Act directs is that over time, that additional payment, which amounts to about $3.30 per month per beneficiary—not the beneficiaries who have chosen the Medicare Advantage plan, that 25 percent—but to every beneficiary is paying that additional amount per month every year to keep Medicare Advan-

tage at that artificially high level. So over time, we are directed to reduce that overpayment and put it more in line with Medicare fee-for-service. And we have begun that, and, I would suggest, still have, we anticipate, a very robust program. But the overpayment is calculated by the Congressional Budget Office to yield about $140 billion over the next 10 years.

Mr. VAN HOLLEN. Right. And again, people can choose currently to go down that road. They are not forced to go down that road as the Republican budget plan would do. But they can choose it. And as you pointed out, we, meaning the taxpayer and the Medicare program, were subsidizing those plans at 114 percent of fee-for-service, meaning not only were taxpayers paying more for individuals in that plan through Medicare, but other Medicare beneficiaries were cross-subsidizing those plans; is that correct?

Secretary SEBELIUS. That is correct. And over the period of time, also, there has been a pretty careful analysis of were there additional health benefits that were attributable to the additional expenditure. And the answer is no.

Mr. VAN HOLLEN. Right. Now, under Medicare Part C, under Medicare Advantage, there is a wide range of ability to experiment with co-pays and premiums and many of the tools that we are talking about; is that not the case?

Secretary SEBELIUS. There is opportunity certainly to experiment and to, you know, develop different plan strategies. There are limitations on how much those costs can be shifted on to beneficiaries and particularly how much the plan design could be used to cherry-pick among healthier seniors or sicker seniors. But given those limitations, yes, there is a lot of opportunity for innovative care strategies by the private market.

Mr. VAN HOLLEN. Okay. Now, I just want to turn to Medicare Part D, the prescription drug plans, and ask you a few questions about that because it is the case that the expenditures came in under projections. If you read the Medicare actuaries, they point out two major factors there. One was that the cost of prescription drugs in the overall market went down because of a competition from generics. And Number two, fewer people actually chose to enroll in Medicare Part B than had originally been projected which, of course, would bring down the costs. But of course, one of the features of the prescription drug bill, Medicare Part D, when it was passed in 2005, was to deny the Medicare program the ability to negotiate or bargain for drug prices.

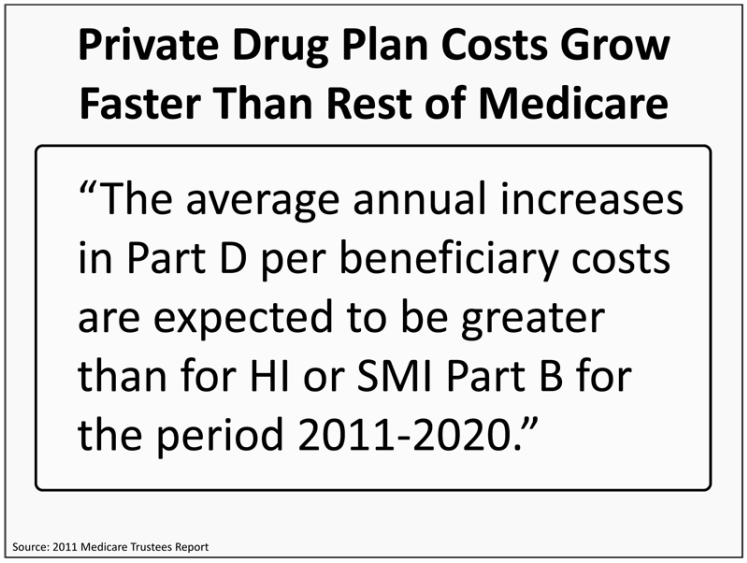
The other change that was made was that for people who were so-called "dual eligibles," people who were on Medicaid and Medicare, previously Medicare of course had not covered prescription drugs, but the Medicaid individuals had been—we had gotten a better rebate, meaning a better deal from the prescription drugs companies than when those individuals also got prescription drugs under Medicare. Can you—that is money that is lost to the Medicare program; is it not?

In other words, reduced drug prices for the Medicare programs represent savings that could be plowed into the Medicare program and extend the solvency of the program; is that not correct?

Secretary SEBELIUS. That is correct. And I think in most States around the country, the negotiation of drug prices, formularies, and

rebates are something that most Governors take seriously with the Medicaid program, and that is not a framework that the Medicare program operates under.

Mr. VAN HOLLEN. And if we could go to the fourth slide.

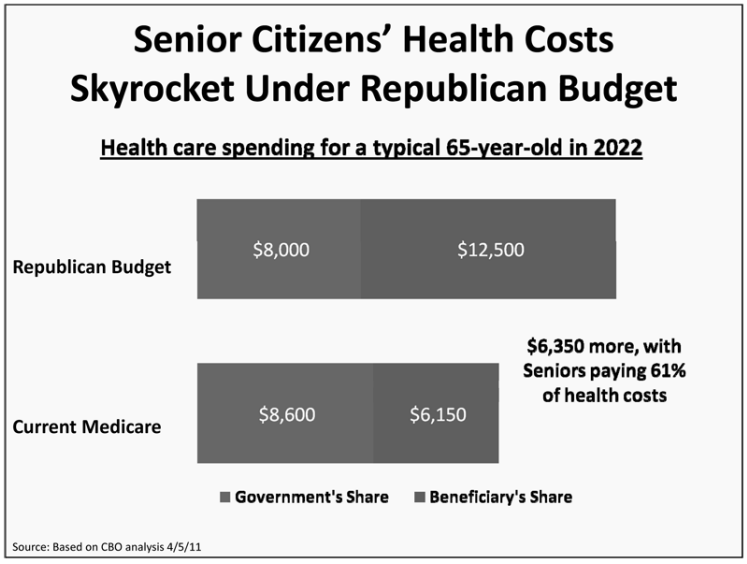


And we are going to have the Medicare actuaries here tomorrow. But this is an interesting point that they made in their most recent report which says the average annual increase in Part D per-beneficiary costs are expected to be greater than for HI, that is Part A Medicare, or SMI, Part B, for the period of 2011 through 2020. So Part D which, as the chairman said, has this competition feature, but where the bargaining for the price of drugs is splintered into subgroups as opposed to being able to get a better deal for the whole group, like we do under the Veterans Administration, but what this chart shows is that the Part D is actually expected to grow more per beneficiary than Part A and B. Could you comment on that?

Secretary SEBELIUS. Well, Mr. Chairman, I do think that trends in part are up because there are definitely some more expensive but very significant new drugs on the marketplace. And that will continue to be part of the framework. But I also think that there are some tools that we are still missing.

I know in the chairman's home State of Wisconsin, there is a senior care program which was negotiated, put into effect by the Governor, and is very popular with a lot of seniors in Wisconsin, and still operates as a stand-alone drug plan, which can be a choice for those seniors. And the costs that Wisconsin seniors pay for senior care is significantly below what Wisconsin seniors can choose from in Medicare Part D. So that we have a real-life example in the State where there is a State-negotiated plan, side by side with the Part D multiple choice plans, and the costs are, I would say, significantly different.

Mr. VAN HOLLEN. Thank you. I am going to wrap up, Mr. Chairman, with a couple of slides. Just if we can go back one slide.



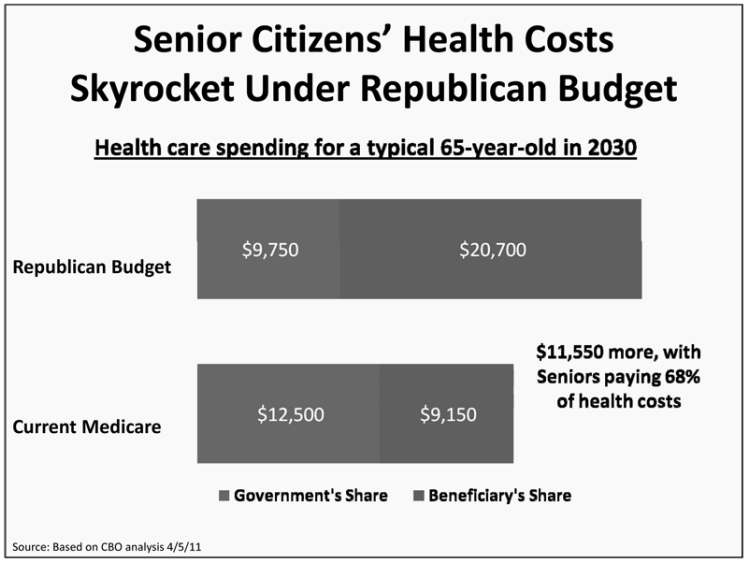
What this shows are the projected CBO costs in 2030. And again recognizing the fact that the Medicare program is able to negotiate better prices and bring down the cost, Madam Secretary, do you know what the average costs for a senior was for health insurance in 1965 before we passed the Medicare program?

Secretary SEBELIUS. The average cost per senior?

Mr. VAN HOLLEN. The average cost for health care—the distribution of costs born by the senior compared to the government or other sources.

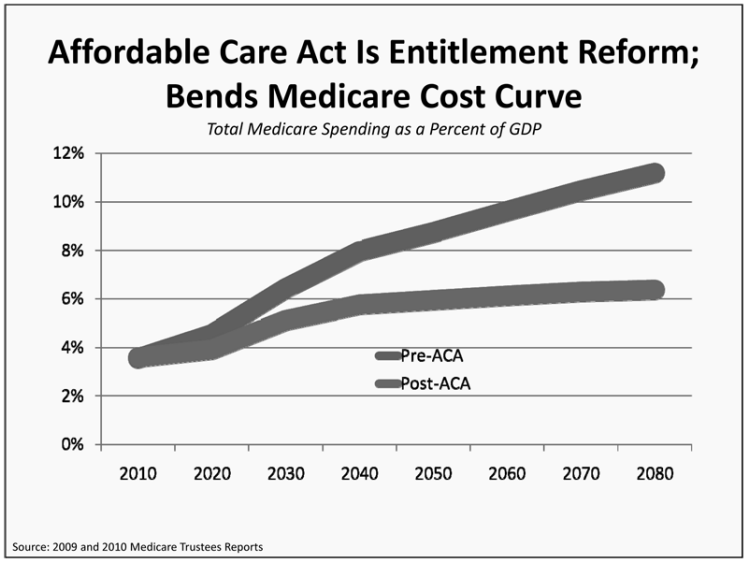
Secretary SEBELIUS. Well, it is my understanding that first a number of seniors, a majority of seniors, had no health insurance at all. And secondly, that those who had insurance or some kind of coverage were often paying about 65 percent of their own costs and that there was some payment for the remainder at the time.

Mr. VAN HOLLEN. So some had none at all, and some had to bear the burden that we would go back to under the Republican proposal. If we could go back one more slide.



This is the 2022 numbers. Again, it is the double whammy. It is the fact that seniors will go into the private insurance market and face higher costs and get less support in 2022, even though immediately the benefit the Secretary talked about with respect to closing the prescription drug doughnut hole goes away.

And then if we just go to the last slide, this is the Medicare actuary showing how the Affordable Care Act does then prosper.



Thank you, Mr. Chairman. Thank you, Madam Secretary.

Secretary SEBELIUS. Congressman, one perspective on those cost issues is if you assume that there are a number of seniors in this

country who are living on their Social Security checks, in 2022 the average Social Security check will be a little over $21,000, and that beneficiary, with the start of the Republican Congressional plan, would be paying 59 percent of that Social Security check on their health care costs. That same beneficiary today pays about 26 percent of their Social Security check for health care. So it is a more than doubling what amount of their income would have to go to health care, year one.

Chairman RYAN. I want to get to members because we are going to start the clock. One thing we failed miserably on a bipartisan basis is to learn how to manage the thermostat in this room. Tell your actuary who is coming tomorrow that we are going to work on it.

Secretary SEBELIUS. I thought it was a strategy.

Chairman RYAN. Mr. Price.

Mr. PRICE. Thank you, Mr. Chairman. And welcome, Madam Secretary. We appreciate you joining us today.

Many of us, as you well know, and as a physician have talked about the principles of health care being accessibility and affordability and quality responsiveness to the system, innovation of the system, and choices for patients. And many of us believe that the new law actually harms every single one of these principles.

There is also little trust between patients and folks out there in the Federal Government as it relates to health care. And for a variety of reasons, former Speaker Pelosi on this specific law said we have got to pass the law so we know what is in it. And this, the Independent Payment Advisory Board, a denial of care opportunity for the Federal Government, is one of the things that we now know that is in it. And it ought to be no surprise that there is little trust out there.

I will remind you, Madam Secretary, that the original Medicare legislation says in it—and this is still the law of the land—quote: Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or compensation of any officer or employee of any institution, agency, or person providing health care services.

Madam Secretary, do you think that we have violated that portion of the previous Medicare law that is still the law of the land?

Secretary SEBELIUS. Violated it by passing the Affordable Care Act? By——

Mr. PRICE. No. By having the Federal Government determine what compensation is provided to those caring for patients.

Secretary SEBELIUS. Congressman, I think that the Medicare from day one determined what compensation they would pay for services, medical services, so I guess I am not quite sure what we are doing. I mean, perhaps you are suggesting that from the outset, from 1966 it has been in violation.

Mr. PRICE. That we violate the law and hence there is little trust on the part of patients. And this, the Independent Payment Advisory Board, this "denial of care Board" can only do that by denying payment to physicians. In a recent op-ed, you said, quote: Seniors and taxpayers will have the security of knowing that as skyrocketing costs jeopardize Medicare's future, IPAB is in place to protect Medicare now and for future generations. But in fact if we

talk about the kind of recommendations that IPAB can make, are they able to reach different targets by raising revenue? Can the Independent Payment Advisory Board raise revenue?

Secretary SEBELIUS. No.

Mr. PRICE. Not by law. Can the Independent Payment Advisory Board raise beneficiary premiums?

Secretary SEBELIUS. Well, the IPAB as you know is prohibited by law from cost shifting, from premium increases, from denying benefits. I think there are a number of examples of ways that they could have been effective at a much earlier time. And one of them we just discussed, which is overpayment for Medicare Advantage.

Mr. PRICE. But, Madam Secretary, don't you agree——

Secretary SEBELIUS. Which was the situation with MedPAC for years.

Mr. PRICE. If I may, because I don't get the kind of time that the chair and the ranking member do. The only way that the Independent Payment Advisory Board are able to affect what the physician does for the patient is to deny payment for that provision of services; isn't that correct?

Secretary SEBELIUS. I don't think that is at all correct, Congressman. I think they could look at a lot of the underlying rising costs and recommend payment strategies that much more closely align what doctors tell me they really want to do. So medical homes where the patient——

Mr. PRICE. But they aren't able to institute any of that. All that they can do is deny care or deny payment to the physician.

Secretary SEBELIUS. I don't think that is the case, Congressman. I fundamentally disagree. Medicare Advantage——

Mr. PRICE. I would urge you, Madam Secretary, then, to simply read the section, just read the section.

Secretary SEBELIUS. I know it.

Mr. PRICE. If I may, this gets to the heart of the quality of health care in this country. As a physician, I can tell you that if I am told by the Federal Government that I will not be paid for a service to a physician, what happens in my presentation of the options to that patient as that treating physician is that I may be coerced by the Federal Government into not even presenting that option to the patient. So this is as pernicious as it could be in terms of the Federal Government getting involved in the provision of care to patients, and that is what violates the trust that is so important between patients and physicians, and it is why we on this side of the aisle and some on the other side of the aisle feel so strongly, that to have a denial of care board in place in Federal law is simply a violation of American principles as it relates to health care.

Secretary SEBELIUS. Well, Congressman, I hear what you are saying. I would suggest that the Republican budget proposal, which would eliminate guaranteed benefits for which there will be——

Mr. PRICE. Madam Secretary, you know that is not true. You know that is not true.

Secretary SEBELIUS. Congressman, I think it is——

Mr. PRICE. The point of the matter is that our proposal guarantees——

Chairman RYAN. We have got to move to the next——

Mr. PRICE [continuing]. The provision of care for seniors. It guarantees it.

Chairman RYAN. Let us leave it at that in the interest of time. Ms. Schwartz.

Ms. SCHWARTZ. Thank you.

I would like to continue this conversation somewhat. This is important for us to be talking about what are the really big contrasts here, and the big contrasts when we are talking about the future of Medicare is what we are working on, what passed last year, which is now law, which I want to have you elaborate on, the work of implementing the Affordable Care Act and in strengthening Medicare and getting the best value for our dollars, and I want you to talk about that; but before we get there, to understand the choice that is being presented, the contrast with the Republican plan—we used to call it the Ryan plan, but now that all the Republicans basically voted for it in the House, it is the Republican plan.

This is what the House of Representatives majority, the Republicans, want to do, which is to end Medicare as we know it, offer seniors premium support. We call it a voucher because they can get to shop in the private marketplace, which, as you pointed out, Madam Secretary, is more expensive and does not have the concerns about cost because they simply can raise the premiums, and the more they raise the premiums, the more seniors will have to pay. Estimates are about $6,000 a year per senior, $6,000 starting, $6,000 per senior per year, going up to doubling that, and who knows what in the future.

The cost shift is directly to the seniors with no protections for those seniors, no consumer protections, no guarantees on benefits, and no offering them, I think, what the chairman would say is options. They can choose between expensive plans or plans that don't have all the benefits they can afford. This is not what we want to see happen.

And in contrast, however, I want to say to my Republican colleagues who say that there is no trust in Medicare, most Americans and most seniors like their Medicare, and they want to see it continue, and so do we. So what I think is particularly interesting about what your testimony in this hearing is the very keen focus for seniors in particular about strengthening the benefits and getting better value for the dollars that we spend in Medicare. We know we can do better in delivery of care, and I love some physicians. I actually care a lot about my husband, and my son, and my daughter-in-law and many of the physicians and hospitals that I know, and they are saying they know they can do better. They would like that flexibility; they would like the tools and the innovations to be able to do that.

In the Affordable Care Act we emphasize primary care, we wanted to train more primary care physicians, we wanted to pay them better under Medicare and Medicaid, we wanted to give physicians and hospitals real flexibility in redesigning better coordinated care for seniors in this country in order to provide better care, improve their health and their outcomes, and to save taxpayer dollars.

So I wanted you to give all that up, to repeal the Accountable Care Act as the Republicans want to and replace it with a voucher that seniors can use in the private marketplace that has had, un-

fortunately, not taken these kind of innovative actions the way they might have, but might well now do it in cooperation with what Medicare is doing.

Can you just elaborate on particularly the cost savings, the potential in cost savings, based on the experience that we have already had and the good work that you are doing now in the innovation center with accountable care organizations, with patient-centered medical homes, with health innovation zones, with the reduction in hospital-acquired infections and reduced admissions? The opportunity, I understand, is really in the hundreds of billions of dollars in savings. What a better way to use that dollars to be able to reinvest and keep Medicare strong.

Secretary SEBELIUS. Well, Congresswoman, you are absolutely right, and I think we have just started down the path. In addition to the innovations, and I will talk about those in just a second, I think the new tools that Congress gave us and directed us to use for fraud and abuse are unprecedented, and I think that can yield also some significant dollar savings.

We have just started the predictive modeling computer effort, and I can guarantee you it is going to be very impressive in terms of results. But the innovation center is just launching some of the strategies. The Partnership for Patients we have talked about, which really is aimed at two simple goals to start with, but many more to follow. That is about $50 billion. That is a—according to the CBO, a conservative estimate if we can get more people to participate, lowering hospital infections and preventible readmissions, and that not only helps people in the Medicare system, but anybody who goes into the hospital. If there are fewer infections that people get in the hospital, it is going to help private employers, it will help people——

Ms. SCHWARTZ. The whole point is to reduce the rate of growth of costs across the board. We certainly will thank you.

Chairman RYAN. We would like to get in as many people as possible.

Is Mr. Chaffetz here? No, it is Mr. Stutzman.

Mr. STUTZMAN. Thank you, Mr. Chairman, and thank you, Madam Secretary, for being here today.

I want to touch on the progress of IPAB. And the health care law provided $15 million in fiscal year 2012 to get IPAB up and running. CMS is required to begin calculating the savings targets in 2013. What progress have you made toward setting up the IPAB as a functioning agency?

Secretary SEBELIUS. Congressman, that work has not started. I think the President is consulting with people about possible candidates for the IPAB Board, but there is no setting up an agency before there is a board appointed.

Mr. STUTZMAN. Do you know, are there any qualifications to be sitting on the Board?

Secretary SEBELIUS. Yes. The statute lays out a series of areas of expertise which the Board should have, very similar to what MedPAC Board members currently have, health care providers, health economists, consumer advocates, people experienced with health finance. I think a key difference between the Board qualifications for IPAB and the Board qualifications for MedPAC are no

conflicts of interests. If they are to be an appointed member of the Independent Payment Advisory Board, it must be a full-time assignment and not be an active user of the system or receive payment from the system.

Mr. STUTZMAN. So they will sit—it will be a full-time job; is that correct?

Secretary SEBELIUS. That is the way the statute is.

Mr. STUTZMAN. Any idea what salaries would they be paid?

Secretary SEBELIUS. I think it is the same as—I know it is equivalent of a Federal salary. One hundred sixty thousand dollars? I don't know what it is—but it is a level that is a Federal—I don't know if it is a Federal judge or—I don't really know, I am sorry, Congressman. I can get you that answer.

Mr. STUTZMAN. Okay. Could you please elaborate on the claim that this year's House-passed budget, the Republican plan, if fully implemented would make it so cancer patients would die sooner? Wouldn't a lower quality of care caused by cutting provider payments in half cause patients to die sooner?

Secretary SEBELIUS. Congressman, I think I was at a hearing where I was asked what happens if someone runs out of money in a voucher in the midst of a chemotherapy program, and I said, frankly there aren't a lot of options. Charity care is one, donated care is another, or they just stop taking their cancer therapy and would end up——

Mr. STUTZMAN. Let me ask this——

Secretary SEBELIUS. That was my answer.

Mr. STUTZMAN. Okay. My granddad just passed away, and I have seen how Medicare worked for him. The average couple turning 65 today pays—paid over $109,000 into Medicare over their lifetimes, but they will receive over $343,000 in benefits. As a 34-year-old, and many others who are not even close to the age of 65, will I get the same deal?

Secretary SEBELIUS. I think it depends on what Congress decides to do with Medicare in the future.

Mr. STUTZMAN. Could I get the same deal? At the current levels, if we would stick with the Democrat plan, if we would stick with doing nothing, could I get the same deal?

Secretary SEBELIUS. Well, no one has suggested doing nothing, Congressman. I think that the Affordable Care Act actually took a major step for the first time ever in entitlement reform, and gave us tools at the Centers for Medicare and Medicaid Services to finally align payment with high quality, lower-cost care delivery, and we are trying to accelerate that pace.

Mr. STUTZMAN. But what I don't understand is what the affordable health care plan did was addressed insurance.

Secretary SEBELIUS. No, that is not true. It addresses insurance, but also the care delivery system. It addresses the underlying system in addition to insurance.

Mr. STUTZMAN. So do you believe that health care costs will start declining? Because currently they are roughly at three times the rate of inflation.

Secretary SEBELIUS. Well, actually they have been on a decline. They are right now running lower than inflation. We think that if, indeed, the strategies are effective where you focus more on pre-

ventive care and early intervention, where people are actually healthier as they get to be 60 and 70, you can dramatically improve health care costs, as well as some care strategies which are aimed at delivering more patient-centered care out of hospital systems, keeping people in their homes longer, which is what patients tell me they want, and also what a lot of providers would like to do, but right now the alignment of the payment incentives and the care delivery are not there.

Mr. STUTZMAN. I think that, you know, with these numbers, if $109,000 covers $343,000 in benefits, Americans understand that this is not going to be sustainable over the next——

Secretary SEBELIUS. Well, I would agree, and everybody agrees with that.

Mr. STUTZMAN [continuing]. Decade. It is going to take some big changes.

Secretary SEBELIUS. That is right.

Mr. STUTZMAN. Thank you. I will yield back.

Chairman RYAN. Mr. Blumenauer.

Mr. BLUMENAUER. Thank you, Mr. Chairman.

Madam Secretary, thank you. I would like to just briefly touch a few things.

As I listen to my good friend, the chairman, describe certain things, I wondered if we were talking about the same bill, because certainly you were talking about a very different bill than I heard him talk about.

My understanding is that you testified—and I just picked up a copy of it again just in this section—that the provisions here do not—are not triggered by the IPAB unless and until Congress does not deal with escalating costs in Medicare. Is that correct?

Secretary SEBELIUS. That is correct.

Mr. BLUMENAUER. That is the bill you are talking about?

Secretary SEBELIUS. That is correct.

Mr. BLUMENAUER. If we fail to act, don't get a spinal implant, then they can make recommendations, and it says right here, not rationing, not shifting, but in terms of helping, in terms of delivery mechanisms, but those go into effect only if Congress—and Congress has the ability to overturn those provisions. Is that not correct?

Secretary SEBELIUS. That is correct.

Mr. BLUMENAUER. That is the bill you are reading?

Secretary SEBELIUS. That is the law.

Mr. BLUMENAUER. I listened to my good friend from Georgia talk about what appeared to me to be sort of a fantasy land because he was concerned that Medicare over the years has had some provisions about Medicare reimbursement. Now, my good friend, as a private physician dealing with private insurance, and you have been an insurance commissioner, you are knowledgeable about this, do physicians just willy-nilly submit anything they want, and insurance companies just pay every provision, every condition, every treatment?

Secretary SEBELIUS. No. Rates are negotiated, and benefits are very clearly spelled out.

Mr. BLUMENAUER. And do insurance companies ever push back and deny claims?

Secretary SEBELIUS. Regularly.

Mr. BLUMENAUER. They do?

Secretary SEBELIUS. Yes, sir.

Mr. BLUMENAUER. Okay. I just wanted to get that clear because I thought that was the case.

And so what we are talking about here is just simply being able to have the same sort of provisions that happen in the private sector, except my friends on the Republican side would just turn this all over to insurance companies to do the rationing, the denial, the approval, and seniors will navigate on their own. That is a statement; you didn't have to answer that.

I heard you take my good friend Mr. Ryan's point here that somehow the $373 billion cost, which represents less than what was projected, was somehow a grand bargain for Medicare Part D, and you started to point out something in terms of there were other ways of doing it. Could you—I don't want you to do it now. I don't think you should do the math in your head, but I think it is a very serious question. Could you have some of your certified smart people calculate for us what would have been the cost in 2030 if we just gave our senior citizens the same deal that the veterans get?

Secretary SEBELIUS. We could do that, sir.

Mr. BLUMENAUER. I suspect that it is probably quite a bit less——

Secretary SEBELIUS. I have a lot of certified smart people.

Mr. BLUMENAUER [continuing]. Than the $373 billion that my friend is so excited about. Would you think it might be less for the veterans than what was negotiated?

Secretary SEBELIUS. I would think it is substantially less, yes, sir.

Mr. BLUMENAUER. I think it would be good for us just to get those numbers, because, again, I am concerned that we are talking about a fantasy world where insurance companies don't make decisions denying benefits, don't ration care, don't cut people off; that somehow that the—because the prescription Medicare drug program, unfunded, just sort of launched, did not—was not as expensive as it first projected, that somehow that is a triumph of free-market economics when, in fact, we could produce much lower costs with systems that the government has, and that we have an actual experiment about the cost-effectiveness of this approach with Medicare Advantage.

I am old enough to remember when Medicare Advantage was advanced in the early—because it was going to save money. It was going to be 5 percent less, 95 percent on the dollar was the projection, and because the system was gamed or of inefficiencies, it has been 13 percent more expensive until recently, because of the changes that have been put in place to bring it under control, and all the while seniors are paying a premium. What did you say the extra cost was a month, $3?

Secretary SEBELIUS. I think it is $3.30 per month per beneficiary, and there are about 49 million beneficiaries.

Mr. BLUMENAUER. Thank you very much.

Thank you, Mr. Chairman.

Chairman RYAN. Mr. Ribble.

Oh, before you start, it is my understanding that the Secretary has to go in 10 minutes, so we will get through this, and then what we will do is we will start the Members who did not have an opportunity yet to be at the top of the queue for the next panel.

Mr. Ribble.

Mr. RIBBLE. Thank you.

Madam Secretary, thank you for being here today. I know it is probably not the funnest thing you do in your workday.

Secretary SEBELIUS. It certainly is the warmest.

Mr. RIBBLE. Yes, it is the warmest, and it is a warm greeting that we extend.

Secretary SEBELIUS. I appreciate that.

Mr. RIBBLE. Under the Affordable Health Care Act, I think I understood that we can't deny care; is that correct?

Secretary SEBELIUS. The Independent Payment Advisory Board——

Mr. RIBBLE. No, not the Independent Payment Advisory Board, but under the Affordable Care Act, the denial of coverage is protected by law, you cannot deny coverage; is that correct? I get to keep my insurance company, and I get to keep my doctor, and I can't be denied coverage and things like this?

Secretary SEBELIUS. Well, eventually when there is, in 2014, the health exchanges set up, you will be able to have an ability to come into a market without preexisting health conditions, yes, sir.

Mr. RIBBLE. And once I am in that market, the health insurance cannot be denied to me if I get sick?

Secretary SEBELIUS. That is correct, you can't be dropped.

Mr. RIBBLE. Can't be dropped.

Secretary SEBELIUS. Rescissions are against the law. Companies dropping a beneficiary because they made a technical error, because they got sick, you cannot have that.

Mr. RIBBLE. And that is done through private insurance companies through the exchanges?

Secretary SEBELIUS. That is correct.

Mr. RIBBLE. Okay. So kind of like the Republican plan for seniors; private insurance companies, can't be denied coverage, and if they get sick, they get to keep it?

Secretary SEBELIUS. Well, I think a huge change is that the cost sharing is shifted to seniors and those with disabilities under the Republican plan. There is no plan for underlying delivery system changes, there is no fraud and abuse protections, and I have no idea what the benefit package looks like. Maybe there has been a discussion, but at least I have not seen what the $8,000 voucher would purchase in the marketplace.

Mr. RIBBLE. And since we can't see all that yet, it just seems a little bit disingenuous for my colleagues on the other side of the aisle and members in the administration to project all these salacious claims about the plan since we haven't yet seen it.

Secretary SEBELIUS. Well, we are projecting costs, and that is not us, it is the Congressional Budget Office, which says that a senior would be paying 61 percent of his or her costs starting in year 1 and closer to 70 percent by year 8. That is the Congressional Budget Office, that is a flip of where we are.

Mr. RIBBLE. And the CBO shows a large high cost, don't they?

Secretary SEBELIUS. Pardon me?

Mr. RIBBLE. And the CBO shows a relatively high cost.

Secretary SEBELIUS. That is based on today's costs.

Chairman RYAN. Will the gentleman yield for a moment on that? We asked the CBO about that. They basically said that they can't estimate choice and competition in effect, and so they didn't bother trying. So, number one, they don't—they can look at——

Secretary SEBELIUS. They can look at Medicare Part D.

Chairman RYAN. But they can't measure it.

Secretary SEBELIUS. They can look at the cost increases in Medicare Part D, and they can certainly look at the cost increases in Medicare Advantage, so we have two real-life examples of cost.

Chairman RYAN. The point is they looked at the example in Medicare Part D in the savings, and they did not replicate that in their cost estimates of this plan. They just ignored it.

Mr. RIBBLE. Thank you for the clarification, Mr. Chairman.

Madam Secretary, during the testimony today regarding IPAB, you said that—not only in your written testimony, but in comments you said that they are prohibited from cost shifting, premium shifting, payment denial, rationing care, raising premiums, reducing benefits, changing eligibility. I think you mentioned that they are going to be paid something for their work, you don't really know how much, but yet you call them a backstop. If they can't do any of these things, what are they backstopping?

Secretary SEBELIUS. Well, let me give you two examples, Congressman, about the kinds of things that, if they had been enacted a lot sooner, I think we could have saved billions of dollars. We have just discussed Medicare Advantage, the overpayment which has gone on for decades, and actually the MedPAC group, the group of advisors has recommended looking at that strategy, lowering it to fee-for-service for years. That has never happened.

The other thing that has recently happened, and again Congress started down this path as long ago as 2003, is our recent experience with competitive bidding for durable medical equipment. It started in 2003, it got a jump start in 2008, it was withdrawn again. This year we have implemented in one of the Medicare sections, we are saving 32 percent over the cost we were paying last year for durable medical equipment. There is no change in beneficiary benefits. They are getting the services they need, but at a third of the cost.

I think those are two kinds of recommendations that don't fall into any of the prohibited categories that could yield billions of dollars.

Mr. RIBBLE. Okay, thank you very much.

Mr. Chairman, I am going to yield back to give my colleagues more time.

Chairman RYAN. Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman.

Secretary Sebelius, it is nice to see you again. Thank you for your testimony.

I want to pursue this line of questioning about competition and the effects of competition, particularly as it relates to health care. Doesn't the ability of competition to—or the potential for competi-

tion to reduce costs depend on a fully informed, fully free negotiation on both sides?

Secretary SEBELIUS. Usually that is what a market strategy is.

Mr. YARMUTH. And with regard to Medicare Part D, I think certainly virtually everyone had the same experience that I did, that my constituents for a long time were extremely confused, and many still are confused, about what their choices are under the prescription drug program. Is that likely, assuming that we were to enact the Republican proposal, that this would be an enormous problem for America's seniors to actually be in a position to intelligently compete with the insurance companies' approach at marketing?

Secretary SEBELIUS. Well, Congressman, what we have done, at least in the last 2 years, in some of the Medicare Part D programs, we have also done it a bit in Medicare Advantage programs, is try to eliminate programs that actually have very little differential, but just add more confusion to the marketplace to do just that.

But, yes, I think it is not uncomplicated. We used to run a senior Medicare counseling program, and many people want to make the best choices. They often, though, in Part D would find themselves in a program, the drug regimen would change in that program only to find out that the drugs that they need have actually shifted out of the program. So that is a pretty common phenomena for seniors.

Mr. YARMUTH. And so then if you add benefits for hospitalization, physician choice, home health care, medical equipment, and potentially hospice, and who knows what else, it makes it an extremely, even more complicated way for—complicated procedure for a senior to go through, a senior and his or her family to go through.

Secretary SEBELIUS. Well, I definitely think that there is a huge ongoing effort to educate folks about what the benefits are and how to take the best advantage of them.

You know, one of the points we haven't really touched on, but I do want to mention, is just the additional cost of administration. Most insurance companies, even the most efficient ones, run at about 11 to 13 percent. Some are as high as 25 percent. Medicare has about 2 percent or less administrative costs. So assuming you have X amount of dollars, a fixed contribution, whatever that fixed contribution can buy in health benefits, less of it is going to go pay for health services in the private market than in the public market.

Mr. YARMUTH. And granted that the Republican proposal has not been put into legislative language that we could actually look at, but if you consider the statements that have been made from the other side that nobody can be turned down, that nobody can be denied service, and nobody can be denied the choice of the physician under the Republican plan, do those stipulations make it much more difficult for insurance companies then to actually lower costs?

Secretary SEBELIUS. Well, again, insurance companies, you know, to my knowledge, have a network of doctors, so they do accept some and deny some on a regular basis. They negotiate with hospitals. Some are in, some are out. They negotiate with drug—I mean, that is part of the strategy to put a plan together. And then when you buy that insurance, you are buying basically that network, that hospital system, that group of providers. It is, I think, a different system than Medicare currently, which says to a patient, you can choose any doctor you want. If you don't like this doctor, you can

go to a different doctor. That is not the strategy around private insurance.

Mr. YARMUTH. I guess what I was trying to get at, judging from what has been said from the other side about the Republican proposal, is it likely that they could have a significant impact on overall cost to the system if they can't deny care, they can't deny anyone coverage, and they can't—and they have to provide all the services that Medicare provides?

Secretary SEBELIUS. Well, if you assume that insurance is about selling a product which delivers health care, pays providers, pays hospitals, pays doctors, you know, there are only a limited number of ways that you can reduce costs. You can reduce administrative costs; you can negotiate better prices with all the payers and providers, which is reducing costs; you can aim at better health strategies, which I think can be effective, get a healthier population. I think often in the private market currently that is done by cherry picking. We take healthier people and deny sicker people, so the pool is healthier. You make money that way. But there are a limited number of strategies. Or you can shift costs. And I would say that both the Medicare and Medicaid proposal that passed the House shift costs onto seniors, those with disabilities onto States.

Mr. YARMUTH. Thank you.

Chairman RYAN. Madam Secretary, I wish we had more time to get into all of this. I obviously have a strong difference of opinion of your interpretation of what we are doing, but I don't think you like our interpretation of what you are doing. This is an issue we are going to have to get into in much more detail. It affects nothing more than the health care security of our Nation's seniors. We have a strong difference of opinion on who ought to be in charge of their health care, them or this Board. I wish we had more time to get into it. The Members who have not yet had the opportunity to ask will be front of the line for the next panel. And with that, Madam Secretary, I know it was a hot morning. Thank you for your indulgence. I appreciate it and hope we can do this again.

Secretary SEBELIUS. Thank you, Mr. Chairman.

Chairman RYAN. Thank you.

Chairman RYAN. Next we will hear from our next panel. If the panel can proceed to the dais, go ahead and take your seats so we can get started.

Our second panel consists of former CBO Director Doug Holtz-Eakin, Grace-Marie Turner of the Galen Institute, and Judith Feder. Is it Feder?

Dr. FEDER. It is Feder.

Chairman RYAN. Feder, thank you. It is one of the two. Judith Feder of the Urban Institute.

Because we have votes, it looks like at about 1:20, we are going to stick to the 5-minute rule for our panelists, so if you could confine your opening remarks to 5 minutes, and then we will do the questioning, as I mentioned earlier, and if there are additional points the panelists want to interject, they can do so during the questioning.

Let us start with you, Mr. Holtz-Eakin, and then we will work our way from our right to left, your left to right. Thank you, Mr. Holtz-Eakin.

STATEMENTS OF DOUGLAS HOLTZ–EAKIN, PRESIDENT, AMERICAN ACTION FORUM; GRACE–MARIE TURNER, PRESIDENT, GALEN INSTITUTE; AND JUDITH FEDER, PH.D., PROFESSOR AND FORMER DEAN, GEORGETOWN PUBLIC POLICY INSTITUTE AND URBAN INSTITUTE FELLOW

STATEMENT OF DOUGLAS HOLTZ–EAKIN

Mr. HOLTZ-EAKIN. Thank you, Chairman Ryan, Ranking Member Schwartz, members of the committee. It is always a good day to be back at the Budget Committee, and you have my written testimony. I won't belabor the points there.

There are four simple points I think ought to be made. The first is that, to my eye, the IPAB is a policy error and one that the Congress should reverse as quickly as possible. It is likely to exacerbate existing reimbursement problems for providers in the Medicare system, and as a result impede access by Medicare beneficiaries. It is likely to stifle innovation. The incentives are such that it will target the most innovative and newest therapies, and the IPAB, as part of the status quo for Medicare, is dangerous to beneficiaries, dangerous to the Federal budget, and dangerous ultimately to our economy because it is part and parcel of a broken social safety net system whose spending threatens to drive debt to levels which would harm the U.S. ability to compete and grow.

Let me expand on those only briefly, and then turn it over to questions. The structure of the IPAB is such that it is likely to exacerbate the reimbursement problems. The way the statute is written, much of Medicare spending is off limits, so the Board is likely to have to target something that looks like less than half of the total spending, and thus disproportionate efforts would be focused on that.

The IPAB is given 1-year targets, says you have to get things under control in a year. There aren't many levers you can pull from a proactive quality-of-care or value proposition that you can do on a 1-year basis, and in the end they will start cutting provider reimbursements. It is something we have seen before with the SGR. It is something we will see again. We know vividly from the Medicaid program, where reimbursements are just a bit over half of private payers, that beneficiaries have a great deal of difficulty getting access. That would be the future of Medicare as well more broadly. We have seen, for example, with past episodes in cuts to the physicians under the Medicare program, the SGR, that fully two-thirds of practices have contemplated as changes in their access for Medicare beneficiaries whether they take new patients or not. So I think that is an outlook under the status quo that is dangerous for beneficiaries and dangerous for the American health care system.

It is quite likely to stifle innovation. We know at some fundamental level that innovation is at the core of the ability of the United States to solve its pressing problems in health care, in energy, in education, and a variety of policy areas. Given that there will be a mandate to cut spending, the most likely targets are those new therapies, the ones that are just introduced in the market. They have been expensive to develop. They have not yet reached economies of scale. These are going to be the newest, most innovative approaches to things like Alzheimer's and the problems that

face us, and the IPAB will have a disproportionate incentive to stifle those.

From the perspective of someone who is developing the therapies, the IPAB is a tax on the return to these, you are not going to get a return on your investment, and worse it is a random tax. You don't know when it is actually going to pop up and grab the return to your investment. So it will have terrible incentives for the development of new medical science in the United States and, as a result, harm the future quality of care. And then it is part—this focus on trying to cut provider payments and control a broken fee-for-service Medicare system is part and parcel of the status quo that I think we simply have to change in a fundamental way.

We know that these important social safety net programs—Social Security, in red ink, unlikely to survive to the next generation; Medicare, enormous buckets of red ink, $280 billion a year in general revenue flowing in, not going to be—to survive for the seniors in the next generation; Medicaid, the future deserving poor will be unable to receive its services, and in the process they are feeding the deficit problems that this Congress has to grapple with and the Budget Committee is so well aware of—we know ultimately that is not simply a budgetary issue, that is an economic threat of the first order. Erskine Bowles, co-Chairman of the President's Fiscal Reform Commission, called it the most predictable crisis in history.

So the issues that are before us today are whether we will take a policy approach which has led to us being on the precipice of a disaster, or whether we will fundamentally change the structure of the Medicare program and the social safety net. And I would encourage this committee and the Congress as a whole to take the latter approach and to discard this policy error. Thank you.

[The prepared statement of Douglas Holtz-Eakin follows:]

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

Chairman Ryan, Ranking Member Van Hollen and members of the committee, thank you for the privilege of appearing today. In this written statement, I hope to make the following points:

- The Independent Payment Advisory Board (IPAB) is a dramatic policy error that will fail to deliver meaningful reform to the Medicare program.
- The IPAB is likely to exacerbate existing reimbursement problems that already limit access to care for Medicare beneficiaries.
- The IPAB will tend to stifle U.S. led medical innovation in the medical device, pharmaceutical, biotechnology, and mobile health industries.
- If left unaddressed, the Medicare status quo and the IPAB will pose a danger to the fiscal health of the federal government, the U.S. economy, and Medicare beneficiaries.

Let me discuss each in turn.

The Independent Payment Advisory Board (IPAB) is a dramatic policy error that will fail to deliver meaningful reform to the Medicare program.

The creation of the Independent Payment Advisory Board (IPAB) is possibly the most dangerous aspect of the Patient Protection and Affordable Care Act. It should be repealed immediately.

This appointed panel will be tasked with cutting Medicare spending, but its poor design will prove ineffective in bending the cost curve, and instead will lead to restricted patients' access and stifled innovation. Four design elements stand-out as especially troublesome.

First, the board is prohibited from recommending changes that would reduce payments to certain providers before 2020, especially hospitals. Because of directives written into the law, reductions achieved by the IPAB between 2013 and 2020 are likely to be limited primarily to Medicare Advantage (23 percent of total Medicare Expenditures), to the Part D prescription drug program (11 percent), and to skilled

nursing facility services (5 percent).[1] That means that reductions will have to come from segments that together represent less than half of overall Medicare spending.

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

Third, IPAB is effectively unaccountable. In practice, the law makes it almost impossible for Congress to reject or modify IPAB's decisions, even if those decisions override existing laws and protections that Congress passed. It's not really an advisory body, despite its name. The system is set up so that IPAB, rather than Congress and HHS acting under Congress' authority, makes the policy choices about Medicare.

All of this suggests that IPAB is a potent mechanism for undesirable policy. The Independent Payment Advisory Board is at best a band-aid on out-of-control Medicare spending and at its worst a threat to physician autonomy and patient choice.

Saving Medicare from ruin requires nothing short of total and comprehensive reform. Adding in more cuts to a broken system does not make it any less broken. The IPAB proposals will be short-term fixes and cuts. We need long-term thinking and long-term solutions. We need to move the focus from merely containing costs to focus on how to get the most value for our health care dollars.

The IPAB is likely to exacerbate existing reimbursement problems that already limit access to care for Medicare beneficiaries

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

Today, Medicare coverage no longer guarantees access to care. Increasingly seniors enrolled in the Medicare program face barriers to accessing primary care physicians as well as medical and surgical specialists. The New York Times, Bloomberg News, and Houston Chronicle are among many newspapers reporting that doctors are opting out of Medicare at an alarming rate. For example, the Mayo Clinic, praised by President Obama and the IPAB's architects, will stop accepting Medicare patients at its primary-care clinics in Arizona.

The physician access problem stems from Medicare's below-cost reimbursement rates and the uncertainty surrounding the Medicare sustainable growth rate (SGR) formula for physician payments. IPAB introduces further uncertainty into physician reimbursement and is likely to force more physicians to begin making difficult Medicare practice decisions.

Table 3 shows the impact on physician access for Medicare enrollees the last time a major payment reduction loomed. In response, 11.8 percent of physicians stopped accepting new Medicare patients, 29.5 percent reduced the number of appointments for new Medicare patients, 15.5 percent reduced the number of appointments for current Medicare patients, and 1.1 percent of physicians decided to stop treating Medicare patients altogether.[2]

Recognizing the increased payment uncertainty, physician practices have started to reshape their practice patterns. Moving forward 67.2 percent of physician practices are considering limiting the number of new Medicare patients, 49.5 percent are considering the option of refusing new Medicare patients, 56.3 are contemplating whether to reduce the number of appointments for current Medicare patients, and 27.5 percent are debating whether to cease treating all Medicare patients.[3]

Medicare's status quo is fraying the nation's social safety net. The IPAB will only make the net fray more quickly.

The IPAB will stifle U.S. led medical innovation in the medical device, pharmaceutical, biotechnology, and mobile health industries.

By statute, IPAB cannot directly alter Medicare benefits. Instead, the more likely threat to patients is that the IPAB will be forced to limit payments for medical serv-

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**The views expressed herein are my own and do not represent the position of the American Action Forum. I thank Nathan Barton, Emily Egan, Hanna Gregg, Carey Lafferty, Michael Ramlet, and Matt Thoman for their assistance.*

[1] "Medicare Benefit Payments, by Type of Service, 2010 and 2020," Medicare Chartbook, Fourth edition, The Henry J. Kaiser Family Foundation, 2010, *http://facts.kff.org/chart.aspx?cb=58&sctn=169&ch=1799.*

[2] Medical Group Management Association. 2010. Sustainable Growth Rate Study. *http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=39774*

[3] Medical Group Management Association. 2010. Sustainable Growth Rate Study. *http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=39774*

ices. In the process, it will effectively determine that patients should have coverage for one particular treatment option but not another, or must pay much more for one of the treatment options.

This is especially troubling because it may choose to disproportionately focus on expensive new treatments. New medicines for conditions like Alzheimer's or Parkinson's will likely have rapid cost growth, especially early after their introduction. That will make them targets because the IPAB is directed to focus on areas of "excess cost growth." Worse, because about one-half of spending is off limits until after 2020, there will be a disproportionate and uneven application of IPAB's scrutiny and payment initiatives.

U.S. medical innovation leadership is dependent on whether the regulatory environment nurtures growth or suppresses innovation. The Affordable Care Act substantially increases the cost of innovation and the IPAB creates a level of uncertainty that will likely drive away venture capital investment in start-up firms and research and development investments from established firms.

If left unaddressed, the Medicare status quo and the IPAB will pose a danger to the fiscal health of the federal government, the U.S. economy, and Medicare beneficiaries.

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

These shortfalls are at the heart of past deficit and projected future debt accumulation. As shown in Table 2, between 1996 and 2010, cumulative Medicare cash-flow deficits totaled just over $2 trillion, or 22 percent of the federal debt in the hands of the public. Including the interest cost on those Medicare deficits means that the program is responsible for 23 percent of the total debt accumulation to date.

Going forward, the situation is even worse. By 2020, the cumulative cash-flow deficits of 6.2 trillion will constitute 35 percent of the debt accumulation. Again, appropriately attributing the program its share of the interest costs raises this to 37 percent.

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

The federal government faces enormous budgetary difficulties, largely due to long-term pension, health, and other spending promises coupled with recent programmatic expansions. The core, long-term issue has been outlined in successive versions of the Congressional Budget Office's (CBO's) Long-Term Budget Outlook.[4] In broad terms, over the next 30 years, the inexorable dynamics of current law will raise federal outlays from an historic norm of about 20 percent of Gross Domestic Product (GDP) to anywhere from 30 to 40 percent of GDP.[5]

This depiction of the federal budgetary future and its diagnosis and prescription has all remained unchanged for at least a decade. Despite this, action (in the right direction) has yet to be seen.

In the past several years, the outlook has worsened significantly.

Over the next ten years, according to the Congressional Budget Office's (CBO's) analysis of the President's Budgetary Proposals for Fiscal Year 2012, the deficit will never fall below $740 billion.[6] Ten years from now, in 2021, the deficit will be nearly 5 percent of GDP, roughly $1.15 trillion, of which over $900 billion will be devoted to servicing debt on previous borrowing.

As a result of the spending binge, in 2021 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory.[7]

A United States fiscal crisis is now a threatening reality. It wasn't always so, even though—as noted above—the Congressional Budget Office has long published a pessimistic Long-Term Budget Outlook. Despite these gloomy forecasts, nobody seemed

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[4] Congressional Budget Office. 2011. The Long-Term Budget Outlook. Pub. No. 4277. *http://cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term—Budget—Outlook.pdf*

[5] Congressional Budget Office. 2011. The Long-Term Budget Outlook. Pub. No. 4277. *http://cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term—Budget—Outlook.pdf*

[6] Congressional Budget Office. 2011. An Analysis of the President's Budgetary Proposals for Fiscal Year 2012. Pub. No. 4258. *http://www.cbo.gov/ftpdocs/121xx/doc12130/04-15-AnalysisPresidentsBudget.pdf*

[7] Congressional Budget Office. 2011. An Analysis of the President's Budgetary Proposals for Fiscal Year 2012. Pub. No. 4258. *http://www.cbo.gov/ftpdocs/121xx/doc12130/04-15-AnalysisPresidentsBudget.pdf*

to care. Bond markets were quiescent. Voters were indifferent. And politicians were positively in denial that the "spend now, worry later" era would ever end.

Those days have passed. Now Greece, Portugal, Spain, Ireland, and even Britain are under the scrutiny of skeptical financial markets. And there are signs that the U.S. is next, as each of the major rating agencies have publicized heightened scrutiny of the United States. What happened?

First, the U.S. frittered away its lead time. It was widely recognized that the crunch would only arrive when the baby boomers began to retire. Guess what? The very first official baby boomer already chose to retire early at age 62, and the number of retirees will rise as the years progress. Crunch time has arrived and nothing was done in the interim to solve the basic spending problem.

Second, the events of the financial crisis and recession used up the federal government's cushion. In 2008, debt outstanding was only 40 percent of GDP. Already it is over 60 percent and rising rapidly.

Third, active steps continue to make the problem worse. The Affordable Care Act "reform" adds two new entitlement programs for insurance subsidies and long-term care insurance without fixing the existing problems in Social Security, Medicare, and Medicaid.

Financial markets no longer can comfort themselves with the fact that the United States has time and flexibility to get its fiscal act together. Time passed, wiggle room vanished, and the only actions taken thus far have made matters worse.

As noted above, in 2020 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory. Traditionally, a debt-to-GDP ratio of 90 percent or more is associated with the risk of a sovereign debt crisis.

Perhaps even more troubling, much of this borrowing comes from international lending sources, including sovereign lenders like China that do not share our core values.

For Main Street America, the "bad news" version of the fiscal crisis would occur when international lenders revolt over the outlook for debt and cut off U.S. access to international credit. In an eerie reprise of the recent financial crisis, the credit freeze would drag down business activity and household spending. The resulting deep recession would be exacerbated by the inability of the federal government's automatic stabilizers—unemployment insurance, lower taxes, etc.—to operate freely.

Worse, the crisis would arrive without the U.S. having fixed the fundamental problems. Getting spending under control in a crisis will be much more painful than a thoughtful, pro-active approach. In a crisis, there will be a greater pressure to resort to damaging tax increases. The upshot will be a threat to the ability of the United States to bequeath to future generations a standard of living greater than experienced at the present.

Future generations will find their freedoms diminished as well. The ability of the United States to project its values around the globe is fundamentally dependent upon its large, robust economy. Its diminished state will have security repercussions, as will the need to negotiate with less-than-friendly international lenders.

Some will argue that it is unrealistic to anticipate a cataclysmic financial market upheaval for the United States. Perhaps so. But an alternative future that simply skirts the major crisis would likely entail piecemeal revenue increases and spending cuts—just enough to keep an explosion from occurring. Under this "good news" version, the debt would continue to edge northward—perhaps at times slowed by modest and ineffectual "reforms"—and borrowing costs in the United States would remain elevated.

Profitable innovation and investment will flow elsewhere in the global economy. As U.S. productivity growth suffers, wage growth stagnates, and standards of living stall. With little economic advancement prior to tax, and a very large tax burden from the debt, the next generation will inherit a standard of living inferior to that bequeathed to this one.

Thank you and I look forward to answering your questions.

Table 1: Annual Medicare Cash Flows

Annual Medicare Cash Flows	1996	1997	1998	1999	2000
Projected Total Income	210.2	212.1	228.2	232.5	257.1
Total Payroll Taxes Collected	92.7	98.8	105.6	112.8	144
Total Premiums Collected	19	19.3	21	19	22
Annual Cash Revenues	111.70	118.10	126.60	131.80	166.00
Annual Expenditures	-200.3	-213.6	-213.4	-212.9	-221.8
Total Medicare Net Cash-Flow	$ (88.60)	$ (95.50)	$ (86.80)	$ (81.10)	$ (55.80)

Annual Medicare Cash Flows	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Projected Total Income	273.2	284.8	291.6	317.7	357.5	437	461.9	480.8	508.2	*486.1*
Total Payroll Taxes Collected	152	152.7	149.2	156.7	171.4	181.3	191.9	198.7	190.9	182.0
Total Premiums Collected	24.2	26.7	29.0	33.4	40.0	48.9	53.5	58.2	65.2	61.80
Annual Cash Revenues	176.20	179.40	178.20	190.10	211.40	230.20	245.40	256.90	256.10	243.80
Annual Expenditures	-240.9	-265.7	-280.7	-308.9	-336.4	-408.3	-431.5	-468.2	-509	-522.8
Total Medicare Net Cash-Flow	$ (64.70)	$ (86.30)	$ (102.50)	$ (118.80)	$ (125.00)	$ (178.10)	$ (186.10)	$ (211.30)	$ (252.90)	$ (279.00)

Annual Medicare Cash Flows	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Projected Total Income	*529.9*	*575.8*	*642*	*700.7*	*786.4*	*808.1*	*914*	*1000.6*	*1094.9*	*1205.5*
Total Payroll Taxes Collected	202.95	217.47	239.10	257.34	284.80	288.59	321.88	347.48	374.95	401.43
Total Premiums Collected	71.01	78.08	88.11	97.32	110.53	114.95	131.58	145.77	161.43	182.03
Annual Cash Revenues	273.96	295.55	327.21	354.66	395.33	403.54	453.45	493.25	536.37	583.46
Annual Expenditures	-568.30	-597.90	-648.40	-703.40	-757.90	-826.40	-902.30	-985.10	-1078.80	-1192.60
Total Medicare Net Cash-Flow	$ (294.34)	$ (302.35)	$ (321.19)	$ (348.74)	$ (362.57)	$ (422.86)	$ (448.85)	$ (491.85)	$ (542.43)	$ (609.14)

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

Table 2: Medicare and the National Debt

CBO & Author's Calculations	1996	1997	1998	1999	2000
Cummulative Medicare Cash Flow	$ (88.60)	$ (184.10)	$ (270.90)	$ (352.00)	$ (407.80)
Interest Paid on Medicare Shortfall	$ (5.70)	$ (11.69)	$ (14.26)	$ (19.84)	$ (24.59)
Total Medicare Debt Burden	$ (94.30)	$ (195.79)	$ (285.16)	$ (371.84)	$ (432.39)
Total Debt Held by Public	**$ 3,734**	**$ 3,772**	**$ 3,721**	**$ 3,632**	**$ 3,410**
Total Medicare Cash Flow as % Debt	*2.4%*	*4.9%*	*7.3%*	*9.7%*	*12.0%*
Total Medicare Burden as % Debt	*2.5%*	*5.2%*	*7.7%*	*10.2%*	*12.7%*

CBO & Author's Calculations	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Cummulative Medicare Cash Flow	$ (472.50)	$ (558.80)	$ (661.30)	$ (780.10)	$ (905.10)	$ (1,083.20)	$ (1,269.30)	$ (1,480.60)	$ (1,733.50)	$ (2,012.50)
Interest Paid on Medicare Shortfall	$ (23.71)	$ (25.77)	$ (26.55)	$ (33.34)	$ (38.83)	$ (51.90)	$ (58.76)	$ (54.29)	$ (56.45)	$ (64.11)
Total Medicare Debt Burden	$ (496.21)	$ (584.57)	$ (687.85)	$ (813.44)	$ (943.93)	$ (1,135.10)	$ (1,328.06)	$ (1,534.89)	$ (1,789.95)	$ (2,076.61)
Total Debt Held by Public	**$ 3,320**	**$ 3,540**	**$ 3,913**	**$ 4,296**	**$ 4,592**	**$ 4,829**	**$ 5,035**	**$ 5,803**	**$ 7,545**	**$ 9,018**
Total Medicare Cash Flow as % Debt	*14.2%*	*15.8%*	*16.9%*	*18.2%*	*19.7%*	*22.4%*	*25.2%*	*25.5%*	*23.0%*	*22.3%*
Total Medicare Burden as % Debt	*14.9%*	*16.5%*	*17.6%*	*18.9%*	*20.6%*	*23.5%*	*26.4%*	*26.4%*	*23.7%*	*23.0%*

CBO & Author's Calculations	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Cummulative Medicare Cash Flow	$ (2,306.84)	$ (2,609.19)	$ (2,930.38)	$ (3,279.12)	$ (3,641.69)	$ (4,064.55)	$ (4,513.39)	$ (5,005.24)	$ (5,547.66)	$ (6,156.80)
Interest Paid on Medicare Shortfall	$ (77.28)	$ (97.84)	$ (121.61)	$ (149.20)	$ (180.26)	$ (216.44)	$ (243.72)	$ (270.28)	$ (299.57)	$ (332.47)
Total Medicare Debt Burden	$ (2,384.12)	$ (2,707.03)	$ (3,051.99)	$ (3,428.32)	$ (3,821.95)	$ (4,280.98)	$ (4,757.11)	$ (5,275.52)	$ (5,847.24)	$ (6,489.27)
Total Debt Held by Public	**$ 10,430**	**$ 11,598**	**$ 12,386**	**$ 12,996**	**$ 13,625**	**$ 14,358**	**$ 15,064**	**$ 15,767**	**$ 16,557**	**$ 17,392**
Total Medicare Cash Flow as % Debt	*22.1%*	*22.5%*	*23.7%*	*25.2%*	*26.7%*	*28.3%*	*30.0%*	*31.7%*	*33.5%*	*35.4%*
Total Medicare Burden as % Debt	*22.9%*	*23.3%*	*24.6%*	*26.4%*	*28.1%*	*29.8%*	*31.6%*	*33.5%*	*35.3%*	*37.3%*

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

Table 3: Impact on Physician Access for Medicare Enrollees

As a result of the uncertainty created by the June 1, 2010 Medicare Part B payment reduction of 21.3 percent, later reversed by Congress, which decisions **DID** your practice implement in June?		Which business considerations are currently **under discussion** by your practice due to this reimbursement uncertainty?	
Stopped accepting new Medicare patients	**11.8%**	Limit the number of new Medicare patients	**67.2%**
Reduced the number of appointments for new Medicare patients	**29.5%**	Refuse to accept new Medicare patients	**49.5%**
Reduced the number of appointments for current Medicare patients	**15.5%**	Cease treating all Medicare patients	**27.5%**
Ceased treating all Medicare patients	**1.1%**	Reduce the number of appointments for current Medicare patients	**56.3%**

Source: September 2010 MGMA Sustainable Growth Rate Study

Table 4: Hospital Economic Impact on a Sample of 401 Non-Profit Stand-Alone Hospitals ($ Thousands)

	Moody's Non-Profit Stand Alone Hospital Credit Rating										
Financial Performance Metrics	**Aa2**	**Aa3**	**A1**	**A2**	**A3**	**Baa1**	**Baa2**	**Baa3**	**Ba**	**B**	**Below Baa**
Sample Size (# Hospitals)	*14*	*38*	*48*	*72*	*78*	*39*	*45*	*29*	*32*	*6*	*38*
PPPACA Adjusted Total Operating Revenue	**$2,143,526**	**$1,312,240**	**$729,216**	**$457,142**	**$381,896**	**$354,088**	**$261,260**	**$180,942**	**$233,253**	**$197,267**	**$233,253**
Total Operating Expenses	**$2,050,665**	**$1,284,712**	**$709,304**	**$458,770**	**$364,209**	**$361,670**	**$265,825**	**$179,093**	**$236,374**	**$207,003**	**$236,374**
Adjusted Operating Margin	**$ 92,861**	**$ 27,528**	**$ 19,912**	$ (1,628)	**$ 17,687**	$ (7,582)	$ (4,565)	**$ 1,849**	$ (3,121)	$ (9,736)	$ (3,121)
Potential Hospital Closures (# Hospitals):				72		39	45		32	6	38

Source: Moody's Investors Service Not-For-Profit Healthcare Medians for FY 2009

Table 5: Hospital Patient Access Impact on a Sample of 401 Non-Profit Stand-Alone Hospitals

Hospital Access Metrics	
Potential Hospital Closures:	232 Hospitals
Potential Decline in Hospital Beds:	69,061 Beds
Potential Loss of Emergency Room Capacity:	14,127,690 ER visits

Source: Moody's Investors Service Not-For-Profit Healthcare Medians for FY 2009

Chairman RYAN. Thank you. Within 12 seconds. Great.
Ms. Grace-Marie Turner.

STATEMENT OF GRACE–MARIE TURNER

Ms. TURNER. Thank you, Mr. Chairman, Mr. Van Hollen, members of the committee.

There is no question that Medicare spending must be constrained if we are going to have any hope of getting overall Federal spending under control, but clearly there is a wide diversity of opinion about the wisdom of using the Independent Payment Advisory Board as a tool. It was designed to take difficult decisions about Medicare payment reductions out of the hands of consumers and legislators and delegate them to this panel of 15 independent authorities, but the Constitution gives the power of the purse to Congress so that elected Representatives can be accountable to the voters in their decisions. The IPAB would turn this principle upside down.

The unelected IPAB members will ultimately determine spending policies that will determine whether millions of seniors have access to the care they need. This challenges the very principle of representative democracy and the consent of the governed. The IPAB is at the center of a conflict between two world views. Do we entrust doctors and patients with decisions, or do we entrust those decisions to a government-appointed panel of experts in Washington who will have authority over hundreds of billions of dollars in Medicare spending?

The government approach to holding down Medicare spending traditionally defaults to making deeper and deeper reductions in payment rates to providers rather than implementing reforms that reward innovation. The legislation is true to form. And perhaps during the question and answer we can talk a little bit about some of the government's experiments so far in innovation and how those have turned out.

Because of the directives written into the law, reductions achieved by IPAB between 2013 and 2020 are likely to be limited primarily to Medicare Advantage, and to Part D prescription drug program, and to skilled-nursing facility services. If the Board is forced to reduce overall Medicare spending by focusing only on these relatively smaller segments, the cuts would have to be very deep to achieve overall per capita spending reductions. Because any of these moves could have major repercussions on access to care, it would seem that seniors and taxpayers would be much better served if these changes were to be openly debated through the legislative process rather than imposed by unelected officials.

Even before the IPAB cuts began, Medicare actuaries found that large reductions in Medicare payment rates already built into law would likely have serious implications for beneficiary access to care, as the chairman described in his opening remarks. The President would double down on these savings by giving the IPAB even more authority to cut payments to achieve his deficit-reduction goals. It is hard to justify further cuts in Medicare provider payments.

I will skip a little bit.

Clearly repeal is the best solution to begin to get us on a path that can move toward a 21st century health sector. Part D shows us the way. We have a working model that shows that when private companies compete, and, importantly, when seniors choose, that you can get costs and spending down both for seniors and for taxpayers. The average monthly beneficiary premium for Part D coverage will be $30 in 2011, far below the $53 a month forecasted originally. Eighty-four percent of Part D enrollees are satisfied with their coverage and 95 percent say their coverage works well.

But looking beyond IPAB and looking beyond Part D, Chairman Ryan has proposed a comprehensive plan to modernize Medicare that builds on the Part D model. The key is premium support, which provides seniors with an annual subsidy to purchase a guaranteed Medicare health plan. When it begins in 2022, seniors would receive an age-adjusted allocation so they can pick the health plan that meets their needs, just as 11 million seniors already have done voluntarily through Medicare Advantage.

Premium support allows for flexible subsidies that can be adjusted and targeted to seniors based upon their age, financial well-being, health status, and similar considerations.

To survive, Medicare must be changed, and the question is whether it will be under IPAB and the rationing built into the President's health care law or through Chairman Ryan's plan that provides a path to sustainability for Medicare. It is a clear choice between this and the top-down approach that puts a small number of independent experts in charge of decisions that will impact tens of millions of seniors and progressively limit their access to care.

Thank you, Mr. Chairman.

[The prepared statement of Grace-Marie Turner follows:]

PREPARED STATEMENT OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

There is no question that Medicare spending must be controlled if we are to have any hope of getting overall federal spending under control. The question is who will make the decisions. There is a wide diversity of opinion and legitimate concern about the new Independent Payment Advisory Board (IPAB) and the powers given in PPACA to its 15 unelected officials who are charged with containing Medicare spending.

In my testimony, I provide an overview of how the IPAB will work, the controversy surrounding the board's powers, and an overview of some of the ideas being discussed as alternative solutions, including widening the baseline for the spending cuts, requiring an evaluation of the overall impact of the payment reductions, and limiting and redirecting IPAB's powers. I conclude that there is a better way: We have a working model in the Medicare Part D program, in which private companies offer prescription drug benefits to seniors and compete on benefit design and price, and which is coming in significantly below projected costs.

- While the IPAB has unprecedented power, allocation of the tools available to the board reveals a fundamental conflict in American health policy: It simultaneously is given broad authority over Medicare payment policy, but its hands are tied in what it can do to reach the mandatory budgetary targets.
- The president wants to double-down on IPAB's powers, giving the board authority to cut payments to doctors even more deeply than called for in the PPACA and giving it the power to "sequester" congressional appropriations.
- The Constitution gives the power of the purse to Congress so that elected representatives can be accountable to the voters for their decisions. The IPAB would turn this principle upside down. The IPAB is at the center of the conflict between two world views. Do we entrust individuals with the decisions for their own care? Or do we entrust those decisions to a government-appointed panel of experts in Washington who will have authority over hundreds of billions of dollars in Medicare spending?

Thank you for the opportunity to testify today about the Independent Payment Advisory Board (IPAB), created by Congress as part of the Patient Protection and Affordable Care Act (PPACA) as a means of containing Medicare spending.

There is no question that Medicare spending must be controlled if we are to have any hope of getting overall federal spending under control. The question is who will make those decisions. Do we trust doctors and patients with decisions about their own care, with new incentives to be partners in managing their health spending? Or do we entrust those decisions to a government-appointed panel of experts in Washington?

The IPAB was designed to take difficult decisions about Medicare payment reductions out of the hands of consumers and legislators and delegate them to this panel of independent experts. The 15 experts, to be appointed by the president and confirmed by the Senate, will have the authority to make binding recommendations for cuts in Medicare payments if per capita spending exceeds defined targeted rates.[1] In that case, the board's recommendations will be sent to Congress at the beginning of each year for fast-track consideration.

PPACA gives the Congress a route to override the IPAB's recommendations, but it raises the bar on the legislative processes in a way that will make it difficult for Congress to intercede. Congress can override or amend the board's recommendations only with a supermajority vote in both houses, and it has a limited time period to pass legislation with alternative cuts that would meet the same spending targets. If Congress does not act in the required timeframe, the secretary of Health and Human Services is required to implement cuts to reach the targets.

Clearly, the IPAB is unprecedented in the power given to unelected officials to direct hundreds of billions of dollars in federal spending. The IPAB will give unelected, unaccountable government appointees the power to make decisions about payment policy in Medicare that will ultimately determine whether millions of seniors have access to the care they need. This challenges the very principles of representative democracy and consent of the governed.

A POWERFUL BOARD WHOSE HANDS ARE TIED

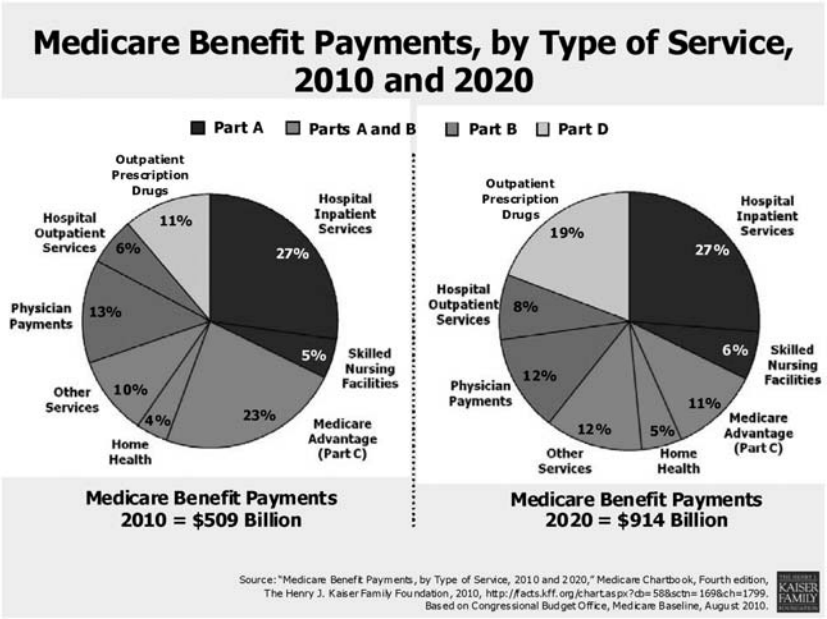
While the IPAB has unprecedented power, allocation of the tools available to the board reveals a fundamental conflict in American health policy: The board is simultaneously given broad authority over Medicare payment policy, but its hands are tied in what it can do to reach the mandatory budgetary targets.

The board cannot make recommendations to improve how Medicare operates. The only real tool it has is to recommend that providers get paid less or to reduce payment for specific items or services. Basically the board will be limited to using Medicare's existing system of price controls and making further cuts in order to reach its targets.

The government approach to holding down Medicare spending traditionally defaults to making deeper and deeper reductions in payment rates to providers for medical goods and services rather than implementing reforms which reward innovation and which could lead to more efficient, more effective, and better-coordinated care delivery. The legislation is true to form.

The IPAB is barred from making changes that would modernize the program's outdated fee-for-service structure. It cannot alter eligibility, increase taxes, or make any changes that would result in rationing, according to the statute. The board's payment decisions, however, will inevitably result in de facto rationing by cutting payments and therefore access to certain benefits.

The board also is prohibited from recommending changes that would reduce payments to certain providers before 2020, especially hospitals (which are subject to a different set of constraints). Because of directives written into the law, reductions achieved by the IPAB between 2013 and 2020 are likely to be limited primarily to Medicare Advantage (MA), to the Part D prescription drug program, and to skilled nursing facility services. That means that reductions will have to come from segments that together represent a fraction of overall Medicare spending. As the accompanying charts show, skilled nursing care represents 5% of Medicare expenditures; outpatient prescription drugs, 11%; and Medicare Advantage, 23%—a share that shrinks to 11% by the year 2020, according to CBO data.[2] If the board is forced to reduce overall Medicare spending by focusing only on these relatively smaller segments of Medicare spending, the cuts would have to be very deep to achieve overall per capita spending reductions.



Limits in payments under Medicare Advantage and Part D are explicitly within the scope of the IPAB's authority. According to a Kaiser Family Foundation analysis, it would appear that the board could set Medicare Advantage payments at or below spending in the traditional Medicare fee for service (FFS) program, and build on provisions in PPACA that set MA payments below FFS payments in some communities. With respect to prescription drugs, it would appear that the IPAB could recommend that Part D plans receive rebates from prescription drug manufacturers in the same manner as state Medicaid programs. It is not clear whether the board could go further—for example, whether the IPAB could recommend lower payment amounts for prescription drugs covered under Medicare Part B, or whether the board could establish a new Medicare-operated Part D plan to compete with private drug plans.[3] Because any of these moves could have major repercussions throughout the health sector, it would seem that seniors and taxpayers would be much better served if these changes were to be openly debated through the legislative process rather than imposed by unelected officials.

MEDICARE ACTUARIES' WARNING

Even before the IPAB's cuts begin, steep Medicare provider payment reductions already are on track because of 1997 legislation that reduces payments under "sustainable growth rate" (SGR) formulas and additional payment reductions called for in PPACA. The Medicare actuary's office recently released its updated alternative scenario,[4] reiterating its projection from last year that the "productivity adjustments" could cause approximately 40 percent of providers to become unprofitable by 2050. The actuaries also find that "the large reductions in Medicare payments rates to physicians would likely have serious implications for beneficiary access to care."

Chief Medicare Actuary Richard S. Foster said in a supplementary report to the annual Medicare Trustees' report that under current law Medicare is on track to pay providers less than Medicaid does, and this would lead to "severe problems with beneficiary access to care."[5]

As a result of cuts in current law, Foster says "Medicare prices would be considerably below the current relative level of Medicaid prices, which have already led to access problems for Medicaid enrollees, and far below the levels paid by private health insurance."

It is hard to justify further cuts in Medicare provider payments when Medicare's chief actuary says it will lead to "severe problems with beneficiary access to care."

Seniors in many regions already are having difficulty finding physicians to see them. If the spending reductions in the law today were to take place, seniors could

face long waits for appointments and treatments, and many would be forced to wait in line in over-crowded emergency rooms to get care, just as Medicaid patients do throughout the country today.

OPPOSITION GROWS

Opposition to IPAB is taking a rare bi-partisan tone in the otherwise politically polarized health reform debate.

U.S. Rep. Allyson Schwartz (D-PA) and at least six other Democrats in Congress have joined Republicans in supporting legislation that would repeal the board.[6]

In a letter to her colleagues, Rep. Schwartz expressed concerns about turning so much power over to a board that will have little or no accountability to seniors impacted by its decisions. "Congress is a representative body and must assume responsibility for legislating sound health care policy for Medicare beneficiaries, including those policies related to payment systems," she wrote. "Abdicating this responsibility, whether to insurance companies or an unelected commission, would undermine our ability to represent the needs of the seniors and disabled in our communities."

The House Republican budget resolution for Fiscal Year 2012, under the leadership of Chairman Ryan, would eliminate the IPAB. Representative Phil Roe, M.D. (R-TN) introduced H.R. 452 in the 112th Congress, the Medicare Decisions Accountability Act of 2011, and Senator John Cornyn (R-TX) introduced S. 668, the Health Care Bureaucrats Elimination Act, both of which would repeal the board. Several groups, including the pharmaceutical industry, the hospital industry, physician groups, and others, have indicated their opposition to the IPAB.

But not all are opposed.

Maya McGuiness, head of the Committee for a Responsible Federal Budget, says: "Outsourcing some of the harder policy decisions is the best chance we have" to contain the growth of Medicare spending.

Henry J. Aaron, Ph.D., of The Brookings Institution, wrote in The New England Journal of Medicine[7] that: "Among the most important attributes of legislative statesmanship is self-abnegation—the willingness of legislators to abstain from meddling in matters they are poorly equipped to manage," he writes. "In establishing the Independent Payment Advisory Board (IPAB) in section 3403 of the Affordable Care Act (ACA), Congress may once again have shown such statesmanship."

He acknowledges that the board is limited in the tools it has to reduce spending and even in the sectors of the health industry where it can cut. Aaron and others conclude that means that for this decade, all of the spending cuts will have to come from "private Medicare Advantage plans, Medicare's Part D prescription-drug program, or spending on skilled-nursing facilities, home-based health care, dialysis, durable medical equipment, ambulance services, and services of ambulatory surgical centers."

Rep. Pete Stark (D-CA), a strong supporter of PPACA, is a strong opponent of the IPAB and called the board "an unprecedented abrogation of congressional authority to an unelected, unaccountable body."

The Arizona-based Goldwater Institute has filed suit to challenge the IPAB. "No possible reading of the Constitution supports the idea of an unelected, standalone federal board that's untouchable by both Congress and the courts," Clint Bolick, the institute's litigation director, said.[8]

Former Sens. John Breaux and Bill Frist wrote just before PPACA was enacted: "[IPAB's] structure * * * raises serious constitutional and process questions * * * For all intents and purposes, the board would have the power to influence and rewrite nearly all aspects of Medicare."[9]

Former White House Budget Director Peter Orszag said that if the IPAB realizes its potential to push Medicare toward paying for better quality care, as opposed to paying for more care, "it could well turn out to be perhaps the most important component of the new legislation."[10]

DOUBLING DOWN ON IPAB

The president wants to double-down on IPAB's powers, giving the board authority to cut payments to doctors even more deeply than called for in the PPACA and giving it the power to "sequester" congressional appropriations. It is far from clear where the constitutional authority is for a board of appointees housed in the Executive Branch to usurp the power of Congress by sequestering funds if Congress were to decide to override its rulings. There would surely be additional legal challenges should the president's sequestering recommendation make it into law.

In his deficit-reduction speech in April of 2011, President Obama said he wants to give new powers to IPAB appointees, proposing they be directed to limit Medicare

cost growth per beneficiary to GDP growth per capita plus 0.5 percent beginning in 2018. The IPAB's targeted cuts are one percent above GDP growth under PPACA beginning in that year. The president also proposed giving the board new powers to sequester congressionally authorized funds if Congress were to overrule the board's decisions.

The White House says that the president's new plan will mean Medicare payments would be lowered by $340 billion over ten years and $480 billion by 2023 to achieve his deficit-reduction targets.

Meanwhile, the president is criticizing the House Budget plan that would put Medicare on a sustainable path and give tomorrow's seniors a choice of private competing plans that would provide them with access to care.

REPEAL IS THE BEST SOLUTION

As documented above, there is growing bi-partisan support for putting responsibility for Medicare payments back in the hands of Congress where it belongs.

While there is widespread agreement that we must reduce the growth rate of Medicare spending, opposition to the IPAB as a vehicle to accomplish this crosses party lines. The strongest concerns involve the power given to the board's unelected officials and the detrimental effect that ratcheting down payments could have on innovation and in limiting access to physicians, medicines, and other medical services.[11]

The Congressional Budget Office has estimated the IPAB would save $15.5 billion between 2015 and 2019.

What is needed is a plan that will achieve the goal of moderating Medicare spending, but in a way that is not destructive to patient access to care and to quality and innovation. A number of alternate solutions are being discussed in the policy community to limit the IPAB's authority or otherwise redirect its responsibilities. A few examples:

WIDEN THE BASELINE

The legislation instructs the IPAB to focus primarily on a narrow range of Medicare spending involving Parts C and D—Medicare Advantage plans and prescription drugs, as discussed earlier. It will be extremely difficult to reach per capita spending growth targets by cutting payments only in these narrow categories.

IPAB could be given authority to consider overall Medicare spending, not just restrictions on pharmaceutical reimbursement and Medicare Advantage, in achieving its spending targets. That would mean including the full range of Medicare spending in the baseline calculations.

BREAK DOWN THE SILOS

The board could be required to evaluate the impact of its directives on overall spending, on access to care, and on innovation. It also should consider the impact of its decisions on the rate of hospitalizations, life expectancy, quality of care, and access to innovative treatments.

DEMONSTRATION PROJECTS

The IPAB could be given the authority to conduct demonstration projects to move away from Medicare's outdated fee-for-service system and show the value of an integrated, coordinated care model. The Florida: A Healthy State program, involving case management of high-risk Medicaid patients, could be replicated for Medicare patients. Programs that facilitate adherence to treatment recommendations, including medications, have been shown to reduce hospitalizations and decrease overall health care costs, with the largest savings gained from the newest medicines. It is essential to consider overall health spending in showing the value of investments in innovative treatments and care management. While many have high expectations for Accountable Care Organizations, may more experiments and demonstrations should be conducted that are not so rule-driven and micro-regulated as ACOs will be.

MEDICAL LIABILITY REFORM

Congress could tie IPAB to a serious effort to reform the medical liability system. There is considerable concern throughout the policy community about the huge amount of money spent on defensive medicine. One colleague suggested we first need a good baseline study so we know how much defensive medicine is costing the country—and Medicare in particular. If the medical liability system were reformed to reduce these expenditures, these savings could be applied to the savings that

were projected from IPAB. This could lead to giving the IPAB a new mission: to monitor the cost of defensive medicine and to recommend ways to reduce unnecessary spending in Medicare.

LIMIT IPAB'S POWERS

As reported, many in Congress are very concerned about the powers given to IPAB and the restrictions in PPACA on Congress' own authority to alter the board's decisions. Legislation is needed that will give Congress more power over IPAB's recommendations, particularly in assuring that the board does not focus on cost reductions at the expense of patient care.

LOCAL QUALITY CONTROL PROJECTS

Health policy analyst David Kendall of the Third Way wrote in a recent article[12] for DemocracyJournal.org that "A better way to approach cost control is local action to improve quality." He strongly supports broader use of best practices employed by the Mayo Clinic and Intermountain Health. But he acknowledges, "It is not yet clear how to bring such quality improvement to scale given a diverse population and a fragmented delivery system. But edicts from Washington to improve quality won't work. It has to come from local physician leadership with the support of the patients, insurers, employers, and taxpayers." He suggested one place to start would be for the Center for Medicare and Medicaid Innovation to "organize regional collaborations among public and private payers to pay for the quality of care instead of the quantity of care."

LONG TERM MODERNIZATION

There is agreement among many health policy experts that a premium support model for Medicare, as proposed by Chairman Ryan, by the National Bipartisan Commission on the Future of Medicare, and many others, is the best way to modernize the program and achieve cost savings in the future. This must continue to be part of any conversation to modernize Medicare.

In any case, a serious conversation would need to begin by laying down some predicates for cost control. What can we do now and what do we need to start planning for the future? The goal needs to be to focus on payment and delivery system reforms rather than payment cuts that will lead to restricted access—the tools that current law gives to the IPAB.

PART D AND THE FUTURE

There is a better way. We have a working model in the popular Medicare Part D program, in which private companies compete to offer prescription drug benefits to seniors.

Created in 2003, Part D provides a range of choices and a subsidy to allow seniors to select the drug plan that best suits their needs. The plans compete on benefit design and price.

The 2011 CBO Medicare Part D baseline forecasts and actual recorded spending show costs for Part D benefit payments have declined by 46% for the 2004 to 2013 period compared with initial estimates of the 10-year cost projections for those years.[13]

And Part D's competitive model is saving seniors money as well. The average monthly beneficiary premium for Part D coverage will be $30 in 2011, far below the $53 forecast originally, and an increase of only $1 over the 2010 average premium of $29.[14]

Recent public opinion surveys show that Medicare Part D enrollees are overwhelmingly satisfied with their Part D coverage. Eighty-four percent of Part D enrollees are satisfied with their coverage, and 95 percent say their coverage works well. Additionally, vulnerable beneficiaries who are dually eligible for both Medicaid and Medicare exhibited the highest satisfaction.[15]

LOOKING BEYOND IPAB

Chairman Ryan has provided a comprehensive plan that builds on the Part D model for Medicare. The key to Ryan's plan is premium support, which provides seniors with an annual subsidy to purchase a Medicare-approved health plan. The plan, when it begins in the year 2022, would provide an age-adjusted payment so that seniors can pick the health plan to meet their needs. The older they are, the bigger the payment they would get. Premium support allows for flexible subsidies that can be adjusted and targeted to seniors based on their age, financial well-being, health status, and similar considerations.

Spending on Medicare and other entitlement programs must be contained. To survive, Medicare must be changed, and the question is whether it will be under IPAB and the rationing built into the president's health care law, or through Chairman Ryan's plan that enables enrollees to apply the government's contribution to guaranteed health coverage while bringing the power of market competition to reduce health costs.

Ryan's plan takes a bottom-up approach, cultivating individual choice, forcing providers to compete to offer seniors the best value in health care, and providing a path to sustainability for Medicare. The president takes a top-down approach that puts a small number of independent experts in charge of decisions that will impact tens of millions of seniors and progressively limit their access to care. It is a clear choice.

SHIFTING THE FOCUS

The Constitution gives the power of the purse to Congress so that elected representatives can be accountable to the voters for their decisions. The IPAB would turn this principle upside down. The IPAB is at the center of the conflict between two world views. Do we entrust individuals with the decisions for their own care? Or do we entrust those decisions to a government-appointed panel of experts in Washington who will have authority over hundreds of billions of dollars in Medicare spending?

There are better solutions than relying on the Independent Payment Advisory Board.[16]

To find savings, Congress could instead focus its attentions on providing better, more efficient care to the nearly nine million people, representing one in five Medicare beneficiaries, who are eligible for services through both Medicare and Medicaid—often called "dual eligibles."[17] They are the poorest and often the sickest beneficiaries, many of whom have multiple acute illnesses and long-term care needs.

They consume about 25 percent of Medicare's spending and nearly half of Medicaid's—more than $250 billion in 2008. Yet 95 percent of them are stuck in an antiquated 1960's fee-for-service payment model and are bounced back and forth between the two programs. Many patients get lost in a crevice between Medicare and Medicaid where no one is overseeing their total care, leading to gaps, duplication, and poor outcomes.

The focus should be on providing tools and solutions for these patients to receive better-coordinated care by contracting with care management plans, a strategy to save money and make these programs work better for vulnerable seniors. Providing them with truly integrated care could significantly improve their care and also help reduce health costs by providing timely, appropriate, managed treatment.

CONCLUSION

The more people learn about the IPAB, the more they will insist that it be repealed and replaced with better solutions.

Health economist Alain Enthoven summed it up in a recent Wall Street Journal commentary:[18]

The 2010 health-care reform's Independent Payment Advisory Board is unlikely to be effective. Appointed by the president, 15 experts with no financial ties to the health-care industry are supposed to dream up cost-cutting ideas that would go into effect unless overridden by a supermajority in Congress. But the reality is that most waste identification and cutting is local. These 15 central planners are unlikely to do as good a job as hundreds of doctors and managers in local delivery systems working with incentives to improve value for money for their enrolled members.

Prof. Enthoven is correct. The IPAB is not the answer, and we must begin now with solutions that will work to make Medicare sustainable for the future.

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Chairman RYAN. Dr. Feder.

STATEMENT OF JUDITH FEDER

Dr. FEDER. Thank you, Mr. Chairman, and Ms. Schwartz, and members of the committee. Glad to be with you today to discuss the role of IPAB, which I believe serves as a guarantor of the ACA, the Affordable Care Act's, investment in assuring all Americans quality care at lower cost.

As you consider the role of IPAB, I call your attention to the fact that Medicare is an enormously successful program, more successful than private insurance, in pooling risk and controlling costs. Medicare has historically achieved slower spending growth than private insurance, and the ACA extends its relative advantage. Action taken in the Affordable Care Act produces an average annual growth rate of 2.8 percent per Medicare beneficiary for the years 2010 to 2021, 3 percentage points lower than national health care spending. National health spending is projected to grow about 2 percentage points faster than GDP growth per capita, and Medicare's projected per-beneficiary spending growth will be a full percentage point lower than per capita GDP.

Growing slower than the private sector is good, but not good enough, since both the public and private sector are paying too much for too many services and failing to assure efficiently delivered quality care. That is why the Affordable Care Act goes beyond tightening fee-for-service payments to pursue a strategy of payment

and delivery reform and creates the IPAB to assure effective results.

The strategy includes payment reductions for overpriced or undesirable behavior and bonuses or rewards for good behavior, most especially through payment innovations that reward providers for coordinated, integrated care efficiently delivered. These reforms have the potential to transform both Medicare and, by example and in partnership, the Nation's health care delivery system to provide better quality care at lower costs.

I have been kind of amazed to hear how little confidence there is in the capacity to reform the overall system and what these achievements of these savings cannot be assumed. That is why the IPAB exists, to recommend ways to achieve specified reductions in Medicare spending by changing the way Medicare pays health care providers. In essence, IPAB serves to inform and assure congressional action to keep Medicare spending under control.

Now, we know that some have proposed eliminating, repealing the IPAB, but along with about 100 health policy experts who recently wrote congressional leaders in support of IPAB, I see that effort as sorely misguided. As we wrote, the IPAB enables Congress to mobilize the expertise of professionals to assemble evidence and to assure that the Medicare program acts on the lessons of payment and delivery innovation the Affordable Care Act seeks to promote.

I would contrast the ACA's strategy to strengthen Medicare with the alternative strategy not only to repeal IPAB, but also to eliminate Medicare for future beneficiaries, replacing it with vouchers for the purchase of private insurance, vouchers, I would call to your attention, that are set taking into account all of the reductions in Medicare payment that we have heard criticized this morning. The CBO analysis shows that such an act will not slow health care cost growth, it would increase the cost of insurance and shift responsibility for paying most of them onto seniors.

Given Medicare's track record relative to private insurance in delivering benefits and controlling costs, morphing Medicare into the private insurance market simply makes no sense. Rather than go in that direction, what we should recognize is that Medicare is clearly doing its part to control costs, having reduced spending per beneficiary considerably and well below that in the private sector. But it can only go so far, as you have noted, on its own to promote efficiencies without partnership with the private sector.

Health care spending growth is not fundamentally a Medicare problem, it is a health care system problem. Effective payment and delivery reform requires an all-payer partnership to assure that providers actually change their behavior, that we do not go on as we have gone, rather than looking to favor some patients over others or to pit one payer against another. Rather than moving to abandon IPAB which supports Medicare's continued and improved efficiency, I urge you to modify IPAB's current spending target to apply not just to Medicare, but to private insurance, indeed all health care spending, and extend its authorities to trigger recommendations for all-payer payment reform if the target is breached. It is all payers promoting efficiently that the Nation very much needs.

[The prepared statement of Judith Feder follows:]

PREPARED STATEMENT OF JUDITH FEDER, PH.D., PROFESSOR AND FORMER DEAN, GEORGETOWN PUBLIC POLICY INSTITUTE, AND URBAN INSTITUTE FELLOW

Chairman Ryan, Ranking Member Van Hollen and members of the committee, I appreciate the opportunity to appear before you today as you consider the role of the Independent Payment Advisory Board established by the Affordable Care Act (ACA). Along with its extension of essential health insurance coverage to tens of millions of Americans, the ACA reduces the federal deficit—in large part because of measures the law takes to responsibly slow the growth in Medicare and overall health spending. Establishment of the Independent Payment Advisory Board (IPAB) is one such measure. The IPAB serves as a guarantor of the ACA's investment in cost-containment.

Having IPAB as a backstop to sustain Medicare's financing is not only critical to securing this vital program that makes health care affordable for older and many disabled Americans; but also to assure that Medicare leads the much-needed transformation of the nation's entire health care payment system—moving from reliance on mechanisms that reward the delivery of ever more, and ever more expensive services, regardless of their contribution to health, to mechanisms that reward high quality care, efficiently provided. In short, the IPAB is part of the Affordable Care Act's commitment to assuring all Americans quality care at lower cost.

As you consider the role of the IPAB, I urge you to consider that:

• Medicare is an enormously successful program—more successful than private insurance in pooling risk and controlling costs.

• Medicare's per capita cost growth has historically been slower than per capita growth in private insurance. But, as a result of measures taken in the Affordable Care Act, Medicare's relative advantage grows dramatically in the coming decade. Its projected 2.8 percent average annual growth rate in spending per beneficiary is projected to be a full percentage point below per capita growth in GDP and three percentage points below growth in national health expenditures per capita. ACA-initiated payment reforms, already under way, have the potential to improve quality and reduce spending growth even further. The IPAB provides a back-up to assure that these savings and efficiencies are actually achieved.

• Medicare is clearly doing its part to control health care cost growth. But spending growth is not, fundamentally, a Medicare problem; it's the problem of the entire health care system. Medicare can only go so far on its own in promoting efficiencies, without partnership with the private sector. Effective payment and delivery reform requires an all-payer partnership to assure that providers' actually change their behavior, rather than looking to favor some patients over others or pit one payer against another.

• What's needed, therefore, is not to abandon IPAB—and certainly not to morph Medicare into less effective private insurance. Rather, we should extend the expertise and authority IPAB focuses on Medicare to apply to all payers—with a system-wide spending target that triggers all-payer payment reform to assure Medicare beneficiaries and all Americans the high quality, efficiently delivered care we deserve. The importance of securing Medicare cannot be overstated. From its inception, Medicare was designed to avoid the problems that plague the private health insurance market. Unlike private insurers, for whom administration, marketing and profits may absorb 15-20 percent of health care premiums, Medicare spends only 3 percent on program administration. While private insurers compete to enroll the healthy and avoid the sick, Medicare pools the overwhelming majority of beneficiaries in a single program—avoiding discrimination based on pre-existing conditions and denials of coverage when people are sick. And, when it comes to costs, Medicare's ability to purchase care from hospitals, doctors and other providers on behalf of virtually all its beneficiaries—rather than having individual beneficiaries or even several insurers negotiate on their own—has historically kept its rate of cost growth per beneficiary below premium growth in private insurance.

The Affordable Care Act promotes cost containment for the future in multiple ways, beginning by setting future payment rates to hold hospitals and other institutional health care providers accountable for productivity gains on a par with those achieved by every other sector of our economy over the past several decades. The result is an average annual per beneficiary growth rate of 2.8 percent for 2010 to 2021—3 percentage points slower than per capita national health expenditures. A this growth rate (3.9 percent per year), national health spending will actually exceed average annual GDP growth per capita by close to 2 percentage points. By contrast, Medicare's projected per beneficiary spending growth will be a full percentage point below growth in per capita GDP. With per capita cost growth slowed, for the first

time in the program's history, enrollment growth has become a major driver of overall Medicare spending.

A slower spending increase than the private sector's, however, does not mean that Medicare uses its dollars as efficiently and effectively as it can—particularly as the aging of the baby boomers and expanded enrollment become a significant driver of its overall costs. Public and private insurers alike pay too much for too many services and fail to assure efficiently delivered, quality care. That's why the Affordable Care Act goes beyond tightening fee-for-service payments to pursue a strategy of payment and delivery reform—and creates the IPAB to assure effective results. Payment reform involves a mix of strategies to support not just cheaper but better care:

• No rewards for 'bad' behavior. The ACA authorizes the Secretary of Health and Human Services to review and alter "misvalued" fees, such as paying more for services than they're worth, and to reduce payments for clearly undesirable behavior, such as hospital-acquired infections or conditions, inappropriate hospital readmissions, and, even more egregious, outright fraud.

• Bonuses for 'good' behavior. Alongside what might be considered these "sticks" to change behavior, the ACA authorizes a set of "carrots," or rewards to delivery of more effective and efficient care. At the most basic level, these rewards are extra payments to providers for doing "good" things—say, meeting a set of efficiency standards while maintaining quality care. But more importantly, these rewards reside in alternative payment mechanisms to replace today's fee-for-service payment system.

• Payment reforms. Among the new payment systems the new health law encourages are "accountable care organizations", collaboratives of inpatient and outpatient providers who will be rewarded for delivering quality care to a defined set of patients at lowerthan-projected costs; "patient-centered medical homes" to promote the financial and health benefits of primary care and chronic care management; and "bundling" separate fees surrounding a hospital episode into a single payment for services associated with a specific condition, such as a hip fracture, which today would include separate fees for diagnosis, surgery, and postoperative care.

These reforms have the potential to transform both Medicare and, by example and in partnership, the nation's health care delivery system to provide better quality care at lower costs. But their achievement and implementation cannot be assumed. To assure that its savings objectives are actually achieved, the ACA's cost containment strategy includes a back-up enforcement mechanism—the Independent Payment Advisory Board or IPAB. The board consists of 15 members, appointed by the President and confirmed by the Senate, to include experts in health economics and insurance, as well as consumer representatives.

The Board is empowered to undertake analysis on ways to promote efficiency in both Medicare and national care spending, and to make recommendations accordingly. But, with respect to Medicare, if spending is projected to exceed the annual Medicare per capita cost-growth target specified in the ACA, the IPAB is required to recommend ways to achieve specified reductions in Medicare spending by changing payments to health care providers, and Congress is required to fast-track consideration of those proposals in the legislative process. Unless Congress votes to reject the proposal (with 60 votes in the Senate) or passes an alternative proposal that achieves similar savings, the Secretary of Health and Human Services must implement the IPAB recommendations. In essence, IPAB serves to inform and assure congressional action to keep provider payment under control.

Some legislators have proposed to repeal the IPAB. But along with about a hundred health policy experts who recently wrote congressional leaders in support of IPAB, I see that effort as sorely misguided. As we wrote, the IPAB enables Congress to mobilize the expertise of professionals to assemble evidence on how payment incentives affect care delivery and to use that evidence to suggest sensible improvements. As an independent, expert, evidence-driven body, we argued, the IPAB will support, not diminish, the Congress' capacity to assure that the Medicare program acts on the lessons of the payment and delivery innovations the Affordable Care Act seeks to promote.

Rather than support this strategy to strengthen Medicare and, indeed, the overall health care system by promoting better care at lower costs, opponents of the Affordable Care Act have proposed not only to repeal IPAB but also to eliminate Medicare for future beneficiaries—replacing it with vouchers for the purchase of private insurance. As analysis of that proposal by the Congressional Budget Office makes crystal clear that strategy would not slow health care cost growth. Instead, it would increase insurance costs and shift responsibility for paying most of them onto seniors. The cost of private insurance is, to start with higher than the cost of Medicare, and, as noted above is growing considerably faster. A voucher set equal to Medicare costs in 2022, when the proposed change would begin, would be insufficient to buy Medi-

care benefits in private insurance. With this voucher, a typical 65 year old's out-of-pocket spending would be about twice what it's projected to be under traditional Medicare—an additional $6000 in out-of-pocket spending—in 2022. And as the gap between Medicare costs and private premiums continues to grow—extra out-of-pocket spending would rise to $11,000 in 2030. Given Medicare's track record relative to private insurance in delivering benefits and controlling costs, morphing Medicare into a private insurance market simply makes no sense.

Rather than replace the IPAB, let alone Medicare, what does make sense is to use the IPAB to align the private sector with the public sector's commitment to health care payment reform and slower cost growth. Medicare payment changes have already brought its spending per capita well below both per capita growth in GDP and per capita private health care costs. And its emphasis on payment and delivery reform can achieve even more. But success in that effort depends on more than Medicare. Medicare can only go so far on its own to promote efficiencies, without partnership with the private sector. Effective payment and delivery reform requires an all-payer partnership to assure that providers actually change their behavior, rather than looking to favor some patients or others or pit one payer against another. Rather than moving to abandon IPAB, which supports Medicare's continued and improved efficiency, Congress should therefore modify IPAB's current spending target to apply not just to Medicare but to private insurance—all health care spending, and extend its authorities to trigger recommendations for all-payer payment reform if the target is breached.

Health care cost growth is not, fundamentally, a Medicare problem—though Medicare is doing its part to control it; it's a health care system problem—and it's the private sector that needs to become a full-fledged partner in Medicare's efforts. As you address concerns about Medicare's future and the fiscal future of the nation, I therefore urge you not simply to recognize IPAB's value in helping slow Medicare cost growth, but also to take action to extend the expertise and authority IPAB provides to move all payers in partnership toward reforms that will deliver better quality care at lower costs. Only payment efficiencies that apply to all payers can assure Medicare and all Americans the affordable, quality care we deserve.

Chairman RYAN. Dr. Feder, I appreciate that very pure statement.

Dr. FEDER. Well, and I appreciate your appreciation, Mr. Chairman.

Chairman RYAN. With that, we are starting with Mr. Flores.

Mr. FLORES. Thank you, Mr. Chairman. I would like to thank the panel for joining us today. I believe IPAB has a Federal flaw built into it, but before we do that, I am going to try to hit some questions quickly.

Dr. Holtz-Eakin, you started your comments talking about the insolvency of Medicare and Medicaid. Can you give me what your perception of those metrics is?

Mr. HOLTZ-EAKIN. All right.

Mr. FLORES. If you looked at Medicare-Medicaid as a private-sector pension plan.

Mr. HOLTZ-EAKIN. We know that Part A of Medicare is running a cash flow deficit right now. Parts B, C, D were never set up to be on their own footing, so they have always counted on what looks to be 79 percent of general revenue. So we have something well over $250 billion, probably close to $280 billion, flowing in out of general revenue to keep the program alive. That is now and it is going to get worse.

Mr. FLORES. If you look at the infinite time frame.

Mr. HOLTZ-EAKIN. It is by March.

Mr. FLORES. My understanding is that Medicare is insolvent to the tune of about $60 trillion; is that about right?

Mr. HOLTZ-EAKIN. These are games that budgeteers play. Let me give you the sad fact. Medicare grows so quickly that there is no interest rate from which you can actually do a discounting exercise

that will cause it to convert, so it is infinitely, infinitely underfunded by any sensible piece of arithmetic. You can only get a number——

Mr. FLORES. So more than $60 trillion?

Mr. HOLTZ-EAKIN. You can only get a number if you assume a miracle occurs somewhere in the future and health care costs grow more slowly.

Mr. FLORES. Right. We are going to get to that in just a second.

And Medicaid is somewhere in the neighborhood of 15- to $20 trillion, right?

Mr. HOLTZ-EAKIN. Yes.

Mr. FLORES. And those numbers together are five times our current national debt.

Mr. HOLTZ-EAKIN. Huge.

Mr. FLORES. Okay. One of my very first economics professors taught me that the laws of economics are like the laws of gravity. The worse you violate them, the harder the impact at the end, and that is essentially what we are in right now. If you look at what has been claimed to be the benefits of IPAB, it says that we can cut costs to providers, but yet not ration health care. So my question for Secretary Sebelius was going to be if we cut the budget for HHS by two-thirds, would she still continue to be able to provide the quality response to her missionary requirements? And I would assume her answer would have been no.

My next question to her would have been if we were to cut the pay for the typical HHS employee by two-thirds, how many young people would want to enter that profession? And so I will ask whichever person on the panel wants to answer, if we cut the pay for doctors by two-thirds, how many young people as they are going into college are going to make the decision to go pre-med and then to follow through all the way through their residency program to become doctors? Anybody want to answer that?

Mr. HOLTZ-EAKIN. I don't know the number, but the incentives are clear, and we have seen this movie before. We have been through this exercise where we say to the beneficiaries, you can have all the medical science you want at low or no cost, and then it costs an enormous amount. So we go to the providers and say, no, no, no, stop that, either literally don't cover that service, or we will cut the reimbursement.

Mr. FLORES. The same thing is going to happen in the technology area. We are going to improve Medicare through technology.

Mr. HOLTZ-EAKIN. And we are going to make the same mistake, the same mistake.

Dr. FEDER. May I comment?

Mr. FLORES. Right. There will be less investment in the industry because there is less money going into the industry to go forward.

One of the things that is caused—one of the claims that is been made by government, by Madam Secretary, was that Medicare's costs have grown at a rate slower than that of the private insurance market, and I can tell you firsthand as somebody who was in business for 30 years before I came here, the reason for that is we began to clamp down on what government health care plans would provide, and all of those costs shifted to the private sector. Does anybody disagree with that?

Mr. HOLTZ-EAKIN. No.

Dr. FEDER. Yes.

Mr. FLORES. I was there.

Dr. FEDER. So was I.

Mr. FLORES. I watched my premium increases go up every year. What caused that in the private sector?

Dr. FEDER. The private sector has been far less aggressive than Medicare in attempting to limit health care costs.

Mr. FLORES. So the government invented the HMO or the PPO?

Dr. FEDER. Actually the government did invent the HMO in the 1970s in the Reagan administration. They actually promoted that policy, and they developed from that point, that is correct.

Mr. FLORES. Let me correct you, though. It came from the private sector.

I don't see how we are going to make this work. We are going to cut pay to the people that provide medical care by two-thirds, and we are going to expect them to stay in the business.

Dr. FEDER. May I comment on that?

Mr. FLORES. Sure.

Dr. FEDER. As I said in my testimony, what I think is there is an assumption that the Medicare system stays the same as it is, that there is no way to improve productivity in the system. The health care industry is the only sector in which we have not seen productivity increases, and, in fact, what the—and I see the chairman nodding. The capacity to achieve productivity increases by delivering health care more efficiently, getting rid of unnecessary readmissions being a primary example. It is out there as a strategy that we all need to pursue and is being pursued by the public. The public is leading. Private payers are doing that as well.

Chairman RYAN. We will let that continue. I want to get to everybody.

Mr. Pascrell.

Mr. FLORES. Thank you.

Mr. PASCRELL. Thank you, Mr. Chairman.

And to add to what the good doctor just said, there were and are three promising models to cut costs and improve quality. If you don't believe in that, then you don't believe in the reform that was passed. One is the accountable care organizations. You have heard those terms, you have heard the discussions about that. Value-based purchasing programs. Very few places have done that. Where it has been done, it has been successful. And payment bundling, which is very, very critical, and a lot of places don't want to do that, do they, Doctor?

So there are many sections. Section 3001 to section 3009 and section 3020 to section 3028 deal very specifically with some things that were not scored by CBO which I believe are going to bring a tremendous amount of—look, when it comes down to it, Doctor, here is where we are at. Democrats want a guarantee benefit program. The other side does not. Regardless of how you slice it, that is what it comes down to. They are entitled to their opinion. I say that with deep respect.

But I want to talk about rationing. Rationing. We have heard that term. It came out the first couple of weeks when we started to discuss health care reform. We want to ration. You know, that

is when it led to those cryptic remarks about we want to push Aunt Tillie off the cliff so we don't have to pay attention to her anymore.

So let us talk about rationing, Mr. Chairman. Over 50 million people in our country are uninsured. Kaiser Foundation, I think, has given us some good figures on that. Twenty-five million are underinsured. We see that in the letters I get, calls I get in my congressional office. I am sure the other guys and gals do the same thing. People cannot afford the care that they deserve and need. They can't do it. Rationing. As you all know, two-thirds of all personal bankruptcies are due to health problems. Rationing.

Just because you have insurance doesn't mean you are covered. We all know that, right? You could get diagnosed with a disease, your doctor could prescribe a comprehensive treatment for you, but if your insurance company says no, what do you do? You call your Congressman. You have little power against the insurance company, and that is what this is all about, Doctor, don't kid yourself.

Just look at all the requests that we get. Am I correct—let me ask you, Ms. Turner, am I correct that this kind of rationing exists under private plans?

Ms. TURNER. People are making choices and decisions all the time about limited resources, both in their financial capacity as well as the capacity of the market to deliver.

Mr. PASCRELL. You can make a choice if you can afford it, if you are given the ability to make that choice. Not everybody can make the choice unless there are options in front of you, options that you fit into, and you don't have to worry about the person who is offering the options saying you don't qualify, or you have this disease and we are not going to cover you. Isn't that rationing?

Ms. TURNER. We have——

Mr. PASCRELL. Isn't that rationing?

Ms. TURNER. We would not have a functioning market in our health sector——

Mr. PASCRELL. Mr. Chairman, is that rationing?

Ms. TURNER. People should have more choices. And the market would provide those choices.

Mr. PASCRELL. Thank you.

Is that rationing, Mr. Chairman?

Chairman RYAN. Does the gentleman want to yield his time?

Mr. PASCRELL. Sure.

Chairman RYAN. I think let us try to get decorum. Having the government deny care to seniors through providers I would count as rationing.

Mr. PASCRELL. Okay. Would you agree with that, Ms. Turner?

Ms. TURNER. Having the government deny care to seniors through a payment policy would also be rationing, yes, sir.

Mr. PASCRELL. How about if insurance companies deny care and coverage to a young couple 40 years of age with three children?

Ms. TURNER. Absolutely. And we need to reform the system so they have more choices and own that insurance.

Mr. PASCRELL. Thank you.

Ms. TURNER. So they can make their own choices in a competitive marketplace.

Mr. PASCRELL. Thank you. Thank you.

It is all choices, but if you have choices out there, real choices.

I yield back, Mr. Chairman.

Chairman RYAN. Okay. I would simply say at least you can fire your insurance company. If you only have the government providing your benefit, you can't fire your government.

Mr. PASCRELL. If you have someone else to take the place of that insurance company, yes.

Chairman RYAN. That is why we are going to fix this problem, we are going to fix the insurance market, we are going to fix health care.

Mr. PASCRELL. Well, the Health Care Reform Act is going to do that, Mr. Chairman.

Chairman RYAN. We respectfully disagree.

Next we have Mr. Mulvaney.

Mr. MULVANEY. Thank you, Mr. Chairman.

As a limited government conservative, it is sort of hard to even know where to start to look at the Health Care Act. I heard Mrs. Sebelius in her testimony just a few minutes ago talk about where she starts when she looks at it, and she said she starts with her father. That got me to thinking about where I start, which is I start with my—I have three sixth-graders, and as I listen to the list of everything that has supposedly happened, all these wonderful things that have happened so far. We have had this magical $250 check go out to all of the seniors right before the election. We had this 50 percent discount now on name-brand drugs. We have got free annual wellness checkups. All I could think of as she was listing those things was who is paying for it, because it is my kids.

And that probably drives my inquiry here. And I think it is interesting that these three sixth graders, have started to read a little bit of Orwell. They have read Animal Farm. They are getting ready to read 1984. And it struck me in Secretary Sebelius' testimony she used some words that I think mean different things to different people. She talked about the IPAB, which you all have talked about as a back-stop or a fail-safe. And I have no idea what that means. I think I know what it might mean. What I think it means is that it is a committee that is set up to do what the administration wants to do if Congress won't do it on their own. And all of her testimony, I think, was partially correct when it came to the IPAB. You heard her talk about the process, about the IPAB would make recommendations on the growth rates, but that the final decision would go to Congress. Maybe. Not exactly true.

In fact, what she didn't say was that IPAB would make the recommendations, and unless Congress either approved that or came up with another way to save the same amount of money or have the same amount of impact, those recommendations would become law. Those recommendations would become law. In fact if Congress, all of Congress, got together and unanimously, Republicans and Democrats, said we don't want to do what this Board just did, that recommendation would still become law.

She also accurately said a part of what the IPAB cannot do. You heard Mr. Pascrell just a few minutes ago talk about the fact that the IPAB is prevented from rationing. They are also prevented from making recommendations to lower—to reduce services or deny coverage or that type of thing.

But here is what they can do. They can, as Mr. Holtz-Eakin suggested, they can recommend reductions in payment for services. In fact, it is one of their primary tools. And this example, while an extreme example, is entirely legal under the law. The IPAB could come out and say, as of next year, the reimbursement rate for a knee replacement is $1. And that is going to save X number of dollars. And unless Congress comes up with a different way to save that $1, then that becomes the law. That becomes the reimbursement rate for knee replacements. And in the event that happens, and doctors stop providing knee replacements for a dollar, then I think there would be a reduction of services.

It is interesting, I think to Mr. Pascrell's point, in the bill, the law goes out of its way to make sure that a reduction, a recommendation to reduce reimbursements, to reduce payments, is not to be deemed rationing. So the IPAB is given the ability to lower those payments, even though it has the effect of rationing coverage.

And I see that Mrs. Feder is disagreeing with me. I will tell you that we talked to CRS actually about that example and it turns out that it is absolutely right. So here is what we have got. We have got this Board that is in charge of innovation, and I am getting to my question, Ms. Feder, and so I will leave it to you. We have got this Board that is in charge of innovation. We have got this Board that is going to be in charge, or could easily be in charge, of up to 20 percent of our economy.

So my question is this: Can someone please—and you get the first chance—give me an example of where that has ever worked in the history of mankind?

Dr. FEDER. I think that we rely on independent boards which have varied records. We rely on a Federal Reserve to manage the banking system. We have got some ups and downs at that one of late. We rely on an Interstate Commerce Commission. We rely on a number of commissions.

Mr. MULVANEY. Does the Interstate Commerce Commission have the right to make law without Congress' approval?

Dr. FEDER. I don't think so, but I am thinking that if I go to you with the Fed, the Fed makes a lot of rules for the banking system, so let me stay there. And what I think is important here—and I do disagree with some of the aspects—I think that some of what you said was not quite accurate because Congress—if everybody in Congress doesn't like the recommendations they can reject them.

Mr. MULVANEY. Only if they come up with another alternative that saves the amount of money.

Dr. FEDER. Sixty votes in the Senate can reject it. But my point is—could I just finish? My point is that what I believe that the Board does for the Congress is give you a source of expertise and tee-up the issues that need to be addressed. And I think that Secretary Sebelius gave us examples of the kind of things they could do, whether it is the—they could promote a patient safety initiative, they could promote better payments, more efficient payments. So I think that there is a tremendous good they can do in bringing expertise to the Congress.

Chairman RYAN. Ms. Feder, you will have to leave it at that.

Ms. Moore.

Ms. MOORE. Thank you so much, Mr. Chairman. I am a little bit interested, Mr. Holtz-Eakin, in this miracle that you were talking about in terms of reducing the trillions of dollars in liability that Medicare faces. And I do agree with you that there is an unfunded liability and how you might reconcile this. You say that you stipulate that health care costs, in general, not just in Medicare, must grow more slowly, which is something I have been harping on continuously. It is not just Medicare, it is the larger health care costs that must grow. But you say that the IPAB is dangerous, that it would stifle innovation. And so I guess your suggestion is that we shouldn't limit the cost in the growth of innovation; that that would be—and you know, we do need innovation. And this, the IPAB targets that.

And many of us allege that, yes, this huge gap between the cost of innovation and all that will be borne by seniors; that this trillions of dollars—if you would support, for example, the Republican plan for Medicare—would target seniors.

So I am asking you to respond to how you see us limiting the cost of health care and also maintaining innovation. I am a little bit more interested in the miracle.

Mr. HOLTZ-EAKIN. So I think fundamentally that the key defect of Federal health programs, Medicare and Medicaid particularly, the Affordable Care Act will be this way, is that they don't impose any budget on those programs whatsoever. They are open-ended draws on the taxpayer, with little incentive for useful adoption of innovations, efficiency, and coordination of care, or any of the things that everyone recognizes would improve the American health care system. And so I am——

Ms. MOORE. So to some extent, you are agreeing with the Affordable Care Act reforms in terms of——

Mr. HOLTZ-EAKIN. It doesn't do anything. There is no budget constraint put on anything here. All it does is say again, as we have done in the past——

Ms. MOORE. But budget restraint, you are not wanting to restrain innovation. So the restraint would come where?

Mr. HOLTZ-EAKIN. I realize there is a vigorous debate in both sides of this committee about the House-passed budget. But among the things that a premium support plan would do is it would cap the taxpayers' liability——

Ms. MOORE. The taxpayers but not the patient, who are also—they are not taxpayers anymore because they are retired.

Mr. HOLTZ-EAKIN. That is one. We both know that fundamentally to be successful, health care costs must grow more slowly. You must stop the overuse of——

Ms. MOORE. Okay. Thank you. I am hearing you say that these trillions of dollars have to be paid for by folks who are no longer taxpayers; they are retired.

Mr. HOLTZ-EAKIN. That is not what I said. For the record.

Ms. MOORE. Well, that is what it sounds like. I will ask Dr. Feder. We heard Secretary Sebelius, we heard the actuary—was it the CMS actuary, Mr. Chairman—say that the Affordable Care Act reforms could generate savings. But he was skeptical that there was the political will to execute them. I am wondering if you think that the IPAB would be an enforcement mechanism that might—

he stipulates that we could recognize savings if there were an enforcement mechanism.

Dr. FEDER. Well thank, you Congresswoman. What I indicated in my testimony is that I think that what the IPAB does, it acts as a back-stop or guarantor to make sure that the innovations that are in the Affordable Care Act, that we are—many of them untested and under development, which may have been what the actuary was talking about, that those actually take place, or that the improvements in demands or accountability for improved productivity for providers, which may have been what he was referring to——

Ms. MOORE. I am going to give you a minute so that you can help Mr. Holtz-Eakin out, because he said that I mischaracterized what he was saying. You know, you guys are all experts in health care, and I am not. I was interested in the miracle of paying for these higher health care costs without sticking it on seniors, and so he talked about needing innovation, and yet and not stifling innovation, but slowing the growth of health care. How would you——

Dr. FEDER. Well, I am not sure what he meant, and I am sure Mr. Holtz-Eakin can speak for himself, as I have heard him before do. But what I believe is that the innovation that moves us away from a payment system that continues to reward forever more, ever more expensive services without regard to benefits for health needs to be replaced with an accountable system that rewards providers for delivering quality care, actually pays docs better.

Ms. MOORE. And not death panels, right?

Dr. FEDER. By no means death panels. We never have been and are not talking about death panels.

Ms. MOORE. Okay. I just want to use my last 6 seconds by saying, I want innovation. I want new technologies available to seniors, but I do think that there has to be some shared payment for the system and not to pass trillions of dollars of costs onto retired seniors.

Thank you, Mr. Chairman, for your indulgence.

Chairman RYAN. Thank you. Ms. Black.

Mrs. BLACK. Thank you, Mr. Chairman. And having been a nurse for over 40 years and being in the health care system, I think there are a lot of things that we could do to reform health care. And we had a great chance to do that and we missed our chance.

But let me go back to IPAB, because as an elected official and also someone who believes in the Constitution, I believe that this IPAB is a very, very serious breach in what Congress should have the authority to do. So there is unprecedented power here to an unelected Board. And I really believe that it is misnamed because it says it is an Independent Payment Advisory Board. But it is not just advisory. It has muscle. It has strength.

And where I have the concern about this is, currently the law says that the Independent Payment Advisory Board will kick in with its recommendations looking at Medicare growth at GDP plus 1 percent. The President has also come out and said that he believes that we need to lower that even to a half percent. Secretary Sebelius was here just a bit ago, and she made a great deal of emphasis on the fact that Congress has the ability to be able to make these recommendations before the Board kicks in.

But let me go to why I think that is a really misinformation piece, is that currently GDP is growing at somewhere between 3 to 4 percent. And I think I am right on that. Medicare is around 7 percent. And if we have got such a low threshold of saying GDP plus 1 percent, IPAB is going to kick in pretty quickly. And when they kick in and they give these so-called recommendations, they are not just recommendations. My understanding is that they are indeed going to be law, or make changes to the way we currently operate, unless there is a two-thirds override, which is a very, very high standard. And we all know how difficult it is to gets two-thirds for anything, unless it is naming a Post Office.

So I have a real problem with that, in addition to the problem with transparency and how this Board is going to operate behind closed doors without public opinion, public comment, and so on. What I would like to hear from each of the members of the panel here is, do you believe that there is a constitutional problem with having a Board making decisions that are going to become law without them being elected officials?

Mr. HOLTZ-EAKIN. I am not a constitutional lawyer, but I do think it is at odds with conventional congressional practice and allocation response to oversight. And I find it troubling from that perspective alone. I am also a bit mystified by some of the other discussion about it. So there has been the notion that somehow it is just a bunch of the smart people who will give ideas for payment systems reform to the Congress, and then you guys will take care of it. There exists such a group. It is called MedPac. I served on MedPac. It is where they send old CBO directors to die. And if it is just a matter of advice, this brings nothing new to the table, and thus will replicate the failure of MedPac.

There is also the notion that it guarantees other successes in the bill. That is not true. I mean, let us stipulate for a moment that the Center for Innovation at CMS will actually do something. I am skeptical, but let's suppose it really does. There is nothing that it can think of that they can put into rulemaking, get implemented, and actually produce results in a year. Those are big changes in payment systems, delivery systems. Everyone knows those are important. They aren't going to happen in a year. So in fact, IPAB is structured to squash any unlikely success you get out of the Center for Innovation.

So I think it is at odds with conventional practice from its setup. I think it is internally inconsistent throughout its claim to the Affordable Care Act, and that is why I think it is a deep policy error.

Ms. TURNER. I do think that IPAB goes further than any legislation, any Board in my experience. And it has not only the ability to have the force of law, but there is no administrative or judicial review. And provisions go into effect unless Congress reaches extremely high hurdles in overruling it, and then, as we have discussed earlier, having to achieve the same targets. And I think that that makes an important point, in that the CBO has already shown it is not going to score quality improvements as really showing meaningful savings, especially in the 1-year time frame that the IPAB has. And so its only tools really are going to be more cuts in payments on the existing fee-for-service system. And we know

where that goes and we know where that leads as far as payment rates and access to physicians.

So I think the miracle that Ms. Moore was talking about earlier is Part D. We know that the marketplace competition consumer power will get prices, costs, down for government programs and that must be the way we go.

Chairman RYAN. Ms. Wasserman Schultz.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman. I think we need to recap. Let's compare Medicare for seniors under the Affordable Care Act and Medicare for seniors under the Ryan Republican plan that passed as part of the Republican budgets.

Under the Affordable Care Act, the doughnut hole is closed over 10 years. The actual, not magical check, Mr. Huelskamp, of $250 that seniors received last year paid for actual groceries, paid for—excuse me, Mulvaney. You are sitting behind Mr. Huelskamp's nameplate. Forgive me. The actual $250 check, not magical, pays for actual groceries, pays actual mortgage, is actual money. So to suggest that somehow the $250 check is mythical or magical or nonexistent is completely false.

I have stood in front of numerous town hall meetings of my constituents, asked for a show of hands of how many seniors got a $250 check last year, and plenty of actual hands go up.

The 50 percent cut in name-brand drugs, the gentleman wonders how it is paid for. I will remind the gentleman that the entire Part D prescription drug plan was never paid for by the Republicans and added $400 billion to the deficit over 10 years, and $7 trillion to the deficit over 75 years.

So when it comes to who made sure that we reduce costs in Medicare, who made sure that when we passed new policy that we ensured that it was paid for, Democrats did so, and preserved and protected and extended the life of Medicare, and Republicans jeopardized it.

In addition, the Affordable Care Act adds preventative screening like mammograms and colonoscopies that used to have a co-pay before the Affordable Care Act passed and that now are free, which means that we shift the focus in Medicare from a sick-care system to a wellness and prevention system. And we ensure that seniors can stay healthy and we save health care costs down the road, because if they get screenings up front then they are less likely to get sick down the road. A wellness check-up, which was not something seniors were entitled to before the Affordable Care Act, a free annual wellness check-up, now they are entitled to that, again, being able to preserve their health rather than having them access the health care system for the first time once they are already sick, which we know would increase costs.

And so let's look at the Republican plan. The Ryan Republican plan to end Medicare as we know it gives a voucher to seniors and leaves them to the whims of the private insurance companies to get health insurance on their own, and adds $6,000, actually more than $6,000, to the bill of Medicare beneficiaries of seniors, all in the name of making sure that we can preserve tax breaks for millionaires and billionaires.

So Dr. Feder, if I can ask you, as you know, we have had some discussion this morning about the IPAB and what it can and can't

do. It is explicitly forbidden from recommending any changes in premiums, any changes in benefits or eligibility or taxes or other changes that would result in rationing. So through those prohibitions, the IPAB can't increase Medicare or beneficiary premiums or cost sharing at all. They can't decide to just tell someone, tell a doctor that a knee surgery is a dollar and that is the end of the story. So accuracy is important.

Do you agree with the assessment that seniors could face higher out-of-pocket costs as a result of the Republican Medicare plan? And could you respond to my comparison of the two approaches to how we preserve Medicare and make sure we bring down costs and protect seniors?

Dr. FEDER. Thank you, Ms. Wasserman Schultz. I do agree with your assessment, and let me give my interpretation of how that occurs. As I indicated, the voucher that is in the Republican budget is set, taking all the reductions in payment growth that we have talked about into account, that—has all been accepted by Republicans in the House—and gives a budget, then, gives a dollar amount for seniors to purchase private insurance, which the Congressional Budget Office says is already more expensive than the Medicare plan for seniors, and will be much more expensive in 2022 when the voucher is expected to start.

What that means is we are sending seniors on their own, will be sending seniors, myself included, on our own to shop for benefits without the ability of having the government behind us to negotiate or set prices on our behalf, determine that the benefits are what they ought to be. So it is simply a cost shift, that according to to the Congressional Budget Office, actually increases costs to seniors.

Ms. WASSERMAN SCHULTZ. And would you say that—it sounds to me like there is no debate over those facts, and those facts are in evidence.

Dr. FEDER. I have not seen any evidence.

Chairman RYAN. We will have to leave it at that. Mr. McClintock.

Mr. MCCLINTOCK. Well, following up on the question of jeopardizing Medicare, Mr. Holtz-Eakin, can you tell us what are the projections actuarially for the bankruptcy of the Medicare system on its current course?

Mr. HOLTZ-EAKIN. The Medicare system as a whole is bankrupt now. I mean it simply cannot pay its bills on a cash flow or a projected basis. So a trust fund for Part A, one tiny little piece, is expected to be exhausted in a bit over a decade.

Mr. MCCLINTOCK. So continuing down the road we are on right now, which is basically the Democratic approach, assures the destruction of Medicare as we have known it or have ever known it.

Mr. HOLTZ-EAKIN. I couldn't agree more. The status quo is dangerous to the beneficiaries, to the budget, and to the economy. And we have to change direction.

Mr. MCCLINTOCK. One thing scaring a lot of the folks in my district now who are on Medicare is they are beginning to feel trapped. They are finding it harder and harder to find doctors who will take Medicare patients. They are having to travel farther and

farther when they find those doctors. Do you have any—that is anecdotal. What is the data on that subject?

Mr. HOLTZ-EAKIN. Well, the latest survey data that I have in my written testimony suggests that two-thirds of physician practices are reviewing their treatment of Medicare beneficiaries. And some of them will be aggressive enough as to not take any new beneficiaries. Some are contemplating it. But each time we go through an episode with both the sustainable growth rate and now the Affordable Care Act promise to cut provider payments, they react in a very sensible business fashion. They say, we can't afford to do this. And they don't.

Mr. MCCLINTOCK. So someone has turned 65. They have to give up their insurance for Medicare. They are now trapped in the Medicare system. They are finding it harder and harder now to find a doctor who will treat them. What is their alternative? What can they do if they can't find a doctor who is willing to take the Medicare reimbursement rate, or have to travel an exorbitant distance to find that doctor?

Mr. HOLTZ-EAKIN. Pay out of pocket 100 percent of the cost, which is exactly the dilemma that Ms. Wasserman Schultz was highlighting.

Mr. MCCLINTOCK. Mr. Stutzman put his finger on the subject, I think, when he pointed to the study that an average couple earning about $89,000, retiring at 65, will have paid into the system about $110,000 and will take out an average of over $350,000. I don't think you have to be a Secretary of HHS or even a Member of Congress to know that that system is not, it cannot be sustained.

It seems to me that there are two ways to address it and those two ways are basically laid out in the approaches of the parties. One of them is price controls, the other is competition. Would you agree with that?

Mr. HOLTZ-EAKIN. I do agree with that. I believe that my worst day as a CBO director was when a Member of the other body asked me what the right price for inhalation therapy was in Alabama. And that is everything that is wrong with the Medicare system, and this continues it.

Mr. MCCLINTOCK. That would also explain why we are now seeing a shortage of doctors. I mean we have got a lot of experience with price controls. They date back in written records as far as Hammurabi and they seem to produce very consistent results. They will, in every case I have ever studied, you know, Diocletian to Nixon, they will produce a shortage of whatever it is that you are controlling the price on. Do you know of any exceptions to that?

Mr. HOLTZ-EAKIN. No.

Mr. MCCLINTOCK. So we have a mechanism that we know will create a shortage. We are already watching it create a shortage. And we have now established an Independent Payment Advisory Board whose principal tool to hold Medicare costs down is to place more and more Draconian reductions into the price controls that are already there, meaning a more and more difficult time for people to find doctors, until you simply can't find them.

Mr. HOLTZ-EAKIN. As I said, that is my deep fear is that this will accelerate what is already broken about the Medicare system, and that is something we can't afford do do.

Mr. MCCLINTOCK. How would you describe the Republican approach to controlling these costs?

Mr. HOLTZ-EAKIN. The approach is I think quite sensible in that it gives a finite amount of resources to a problem; and people, when they have a finite amount of resources, use it efficiently. It allows the best package of insurance benefits at the right price to be selected by the Medicare beneficiary, thus rewarding value, which is how we have been successful in the other 87 percent of the economy.

Mr. MCCLINTOCK. So it is basic competition. Will and Ariel Durant, in their History of Civilization, asked the question, What makes Ford a good car? Chevrolet. The fact that there is somebody there competing to offer better services at a lower price.

But just in the few seconds I have left, the hit on that that we keep hearing is, well, Medicare Advantage works that way and it costs more. Could you address that very quickly?

Mr. HOLTZ-EAKIN. I believe that is a very mistaken statement. Medicare Advantage, when it is a managed plan, is cheaper and offers a better value proposition. The fee-for-service Medicare Advantage plans cost a lot because fee-for-service is broken medicine, regardless of the label attached to it.

Chairman RYAN. Thank you. Mr. Lankford.

Mr. LANKFORD. I want to get a chance to follow up on——

Chairman RYAN. I apologize, Mr. Lankford. It is Mr. Van Hollen. He didn't have a chance this round.

Mr. LANKFORD. Glad to yield.

Mr. VAN HOLLEN. Thank you. Thank you, Mr. Chairman. Thank you. Let me thank all the witnesses.

And I want to just very quickly on the Medicare Part C, we know from CBO and the facts that we had been subsidizing that at about 114 percent of Medicare fee-for-service. But really what I want to do is pursue the line of conversation that Mr. McClintock raised, because you, in your testimony, suggest that it is like really, really hard to find a doctor on Medicare. We just heard that anecdotal evidence suggests it is harder to find doctors. And I think we should all agree that rather than rely on anecdotal evidence, we should just look at the real evidence out there. And, fortunately, a nonpartisan group called MedPac that advises the United States Congress does exactly that survey.

And let me report to you what their most recent findings are because I think it is very—it is informative on this issue. They talk about how every year they conduct a patient survey to overall access to care. And they look at the private market and the Medicare market. And I am just quoting from their report: Results from our 2010 survey indicate that most beneficiaries have reliable access to physician services, with most reporting few or no access problems. Most beneficiaries are able to access, able to schedule timely medical appointments and find new physicians when needed. But some beneficiaries experience problems, particularly when they are looking for a primary care physician. Medicare beneficiaries reported similar or better access than privately insured individuals aged 50 to 64. On a national level, this survey does not find widespread physician access problems, but certain market areas may be experiencing more access problems than others due to factors unrelated

to Medicare, or even payment rates, such as relatively rapid population growth.

Then if you go on, it states: The Patient Protection Affordable Care Act of 2010 contains several provisions to enhance access to primary care, including increasing Medicare payments for primary care services provided by primary care practitioners.

Then if you look at the chart, the table they have, and I just want to read what they ask. This is a survey. This isn't anecdotal: Getting a New Physician. Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, how much of a problem was it in finding a primary care doctor/specialist who would treat you?

Medicare program, the answer being no problem, no problem finding a primary care physician. In 2007, 70 percent said no problem. In 2008, 71 percent said no problem. 2010, 79 percent said no problem.

Let's look at the private insurance market, age 50 to 64, all the things that people said would make it work. No problem has declined from 82 percent say no problem in 2007, to 69 percent saying no problem. Now, 10 percent gap. In other words, Medicare beneficiaries, according to this nonpartisan analysis, have no problem.

Specialists—and I think it is important to get the data out because there is anecdotal—I hear from seniors in my district the difficulty in access. And it doesn't mean that every single physician takes Medicare, just like not every physician is on the plan a lot of us have; I mean, depending on what you choose. But I can tell you, in 1965 Medicare beneficiaries couldn't find—people, 65 and up, couldn't find any physician willing to take them.

Access to specialists, people who reported no problem with access to specialists, 85 percent of Medicare beneficiaries in 2007, no problem; as of 2010, 87 percent reporting no problem with access to specialists. Again, higher than in the private market ages 50 to 64 where 82 percent report no problem with access to specialists.

Mr. Chairman, I would like to submit this for the record. And I do think that this whole conversation requires data. And you know, the notion that all of a sudden—and Mr. Holtz-Eakin, you say in your testimony, today Medicare coverage no longer guarantees access to care. Well, it doesn't mean that every doctor, I agree, signs up to participate in Medicare. But the overwhelming number of doctors do. And in private plans, there are a whole lot of doctors who don't participate in private plans. And I can assure you that under the House Republican plan, when they are going to be providing a much smaller allotment, and you are going to be leaving it to Federal employees to establish the standard benefit plan but insurance companies to decide what benefits they are going to provide, you are going to have a real access problem.

And I would ask Ms. Feder if she could just comment on that issue.

Dr. FEDER. Absolutely. I was listening. I appreciated what you were—you read my mind or we were on the same wave length because of that MedPac evidence. But you had it first. It was in your mind.

The issue that I have been thinking about is what is it that you are thinking that these private health plans are going to be able to provide people in terms of access if you give such a limited voucher? People who can add on the extra dollars may—the very well-off seniors may be able to get a decent plan. But you are not giving them enough money to shop with. So anything that you even think may exist in the current Medicare plan is bound to exist when you have actually given seniors fewer dollars to pay for more expensive plans.

Mr. VAN HOLLEN. Thank you. Thank you, Mr. Chairman.

Chairman RYAN. Now it is Mr. Lankford.

Mr. LANKFORD. I want to be able to respond real quick to the statement that Ms. Wasserman Schultz made earlier. And just talking about, you know, there is nothing in this IPAB that is going to reduce costs or reduce reimbursements or that can't change the prices on things. And that is just not in the law.

In a meeting about 4 weeks ago that freshman legislators of both parties had with Timothy Geithner to be able to talk about some of the President's plan for dealing with deficit reduction in future days, we walked through section by section of many issues with them. One of them was dealing specifically with health care, because at the time the President had not released a plan for how to reduce costs in Medicare and Medicaid and what the plan was. He had made multiple statements saying we need to bring costs down, and we are going to work on that. So we asked him the specifics of that.

Specifically, Timothy Geithner stated the way they we were going to get savings over the next 10 years in Medicare and in Medicaid is by cutting the reimbursement rate to doctors, hospitals, and drug companies through IPAB. So if this is not in the law, someone needs to inform the Secretary of the Treasury that that is not how we are going to get these millions and billions of dollars of savings, because the President's spokesman is stepping out there and saying the way that we are going to accomplish this is by cutting reimbursement rates to doctors, hospitals, and drug companies to gain cost savings for Medicare and Medicaid.

So it is very difficult for me to hear one person say that is not in the law, and then the Secretary of the Treasury say that is the way we are going to accomplish that.

I also have difficulty in processing through the power that has been given to IPAB in saying, because there is medical innovation that needs to be done with how we handle the cost savings, we are going to give this power to this independent group and give them the authority to be able to accomplish this. This is a unique situation to say we have a very difficult issue; apparently Congress is having a difficult time cutting back the costs on this, and so we are going to empower this group to basically create law.

Well, here is my question that I would have asked Secretary Sebelius. GAO makes reports about how to be able to save money in HHS. I am interested, if IPAB has the authority to be able to make recommendations that require a supermajority from Congress to change, to giving to GAO the capacity when they do a risk assessment on HHS and cost savings, the authority to be able to make cost savings suggestions about that. And I would like to em-

power the inspector general of each of these agencies to say when you find fraud, or when someone rises up on the high-risk list, which multiple agencies are on the risk list for GAO, I would like to just empower them the same way IPAB has empowered them. Give them the power of law and to say whatever recommendation you make about how to reform the Department of Energy, the EPA, the Department of the Treasury, whatever it may be, let's just empower the inspector generals and the GAO, when they make recommendations, that they have that same authority with IPAB. Mr. Holtz-Eakin, do you think that is a good idea?

Mr. HOLTZ-EAKIN. No.

Mr. LANKFORD. Why?

Mr. HOLTZ-EAKIN. Ultimately, I believe that the Congress has the responsibility to make these policy decisions. And having made them, the executive branch has the responsibility for implementing them. Congress then has to turn around around and do the oversight. That is the standard of practice in the United States. It has by and large been quite successful, and it is the practice I would suggest you adhere to.

Mr. LANKFORD. Okay.

Ms. Feder, what do you think about that, if we go ahead and empower the inspector general and we empower GAO to go ahead and make recommendations, the same authority that IPAB has?

Dr. FEDER. I think it is different. And what I think that the IPAB does is, they are able to do, which is what I think Ms. Wasserman Schultz was getting at, is to look at, to assess what is going on in payment and make recommendations, as Doug said, not so differently from the way MedPac does, but with more authority to——

Mr. LANKFORD. Not so differently than what GAO does and a lot of other agencies. Very similar. I mean, they look at reports, they go through all these, they make recommendations, they say this would be a great way to save money, hand it to the Congress to make the decision.

Dr. FEDER. I did not advocate it. I will go there. I think that we have an issue in terms of health care cost growth that requires this.

Mr. LANKFORD. Quite frankly, we have an issue with agency growth.

Dr. FEDER. Well, I will stay where I am. I think that the Nation's health care cost growth, not Medicare's, but the Nation's health care cost growth is a matter of dire concern. And I think that this is a mechanism which I would argue leaves authority in the Congress. The Congress can reject it with 60 votes in the Senate, or it can come up with alternative mechanisms in order to achieve spending restraints. And I think that that, at this point in time, is helpful.

Mr. LANKFORD. I would have to say that I don't think that is a good idea to give that authority to GAO either, or to the inspector generals. Neither do I think it is a good idea to give it to IPAB, to be able to say they have some supermajority that they can shut down and create law based on their recommendations.

And with that, I yield back.

Chairman RYAN. Thank you. Mr. Woodall.

Mr. WOODALL. Thank you, Mr. Chairman. I appreciate that.

Dr. Feder, I had a couple of questions for you. I appreciate what you closed your testimony with, that you think IPAB would be a wonderful thing for public and private plans alike. And we get so many shades of gray here it is nice to have some clarity.

Tell me about what Ms. Wasserman Schultz said before she left the room. She said we used to have a co-pay on programs, and now they are free. She was describing some of the changes in the President's health care plan. As we talk about rising costs and how to get those costs under control, when you used to have programs that had a co-pay and now those programs are free, what does your experience lead you to believe? Does that lower cost because you are getting more people in the system, or increase cost because you are having more utilization?

Dr. FEDER. The question is, which services? And the co-pays have been eliminated, as they would be also for other people in the Affordable Care Act, and I think some of that has gone into effect as well for preventive services. And it is based on the premise that getting service, getting a checkup, getting service early, actually reduces the possibilities of more costly illness down the road. It is based on—in some cases it does do that. In some cases it doesn't. But it is based on evidence that is tied to the importance. The best evidence, for example, is prenatal care, not for the Medicare population but for the younger population. Immunizations. So it is preventive service that this focuses on.

Mr. WOODALL. Now, I look at the Federal Employee Health Benefit Plan. I happen to have the absolute cheapest plan that is on the menu. It is an Aetna health savings account. I have access to any physician I want to go to. I have access to any service that I want to utilize, and I pay absolutely nothing out of pocket for those. It all comes out of my medical savings account. And yet it is the cheapest program on the menu.

Why is that true? Why is it that when I am in charge of my care, I get the cheapest plan on the menu, but when all of the benefits are pre defined for me, it actually turns into the most expensive plan on the menu.

Dr. FEDER. I think one of the issues is who is choosing the high-deductible plans, and so you have to look at selection and whether healthier people who do not expect to use services may be actually in those plans, because you do save on the premiums. And I would hope that you have been in good health. And I would venture to suggest that in all likelihood, so that the population being served is a generally healthier population. So I would have to look at that selection issue before making a comparison.

Mr. WOODALL. I am not going to quote you exactly. But as fast as I could write it down as you were responding to a question, you talked about how we get sent out into the marketplace under the Republican health care plan to make decisions without the government to set prices on our behalf.

Dr. FEDER. What I said was that we are as individuals negotiating with insurers, rather than having the government, the public program, Medicare, as an insurer. And I think that I would prefer to have Medicare do it for me, based on what I see in the marketplace.

Mr. WOODALL. Thinking about your vision of having IPAB control private insurers as well, I did have to go in for a chest CT recently, pulled up a list of providers on-line, shopped around for prices. There was about a threefold disparity between the one that was right next door to me, that happened to be three times more expensive, and the one that was about 4 miles across town that was a third of the cost. I got in the car, I paid the $4 a gallon to go get the one that was a third of the cost, because it was coming out of my medical savings account.

Why does government price fixing of a price for everybody across the board lead to a better outcome than me seeing those prices and making that decision on my own?

Dr. FEDER. Actually, let me move it just a little bit to where the Affordable Care Act is trying to go in terms of, I think, having an improved position over the fee-for-service, because I think that there is a problem with paying fee-for-service and having ever more and ever more expensive care. And I will share with you a conservation recently with a private insurer who would like to partner with Medicare in an alternative approach, a medical home approach, in which it would be physicians who would be rewarded for delivering care more efficiently and it would be they, in conversation and working with their patients, who would be selecting the place that was best and most affordable, or, excuse me, most efficient. That is not an issue here. It is the most efficient. And I think that that is a mechanism.

And as I have said, we continue to sound—the conversation sounds as if we are heading down a continuation of health care system as we know it, when in fact the Affordable Care Act is moving us and leading us and working with the private sector to move in a different direction.

Mr. WOODALL. Well, that plan that you described sounds strikingly like the PACE program that Bob Dole championed in the late nineties where you combined Medicare and Medicaid together and let folks make those decisions. I thought that was a wonderful program. I hope we will have a chance to get back to exactly that kind of help.

Dr. FEDER. I appreciate your drawing on PACE because PACE actually turns to—serves the most vulnerable dual-eligibles, people on Medicare and Medicaid who need long-term care, and long-term care in particular is a major problem for people today. And I thank you for interest in that program.

Chairman RYAN. Thank you. If you could bring up chart one, please.

This shows a comparison of inpatient hospital services reimbursements. Right now, Medicare is paying about 66 cents on the dollar to providers. In the outyears it goes down to 33 cents on the dollar. That is where we are right now under current law.

Next chart please, chart two.

Doctors. Right now, we are paying about 80 cents on the dollar. Therefore it is a little higher and therefore the access is not so bad. By 2030 it goes down to 40 cents on the dollar.

The SGR, we have played with this hot potato for a long time, and what we learned out of this experience, the 1997 budget agreement, which is really held up as a hallmark budget agreement—

Republicans working with the Democratic President to get a budget agreement, which, by the way, cut taxes and cut spending—what we got out of that were price controls on Medicare and payment systems which are producing these results. And the current Affordable Care Act finishes the job in going in that direction.

And what we learned out of that, at least our lesson was price controls don't work because, like we said, from Diocletian to Nixon, when you pay less for something, you get less of it. And so what we learned out of that was nursing homes are going out of business. They are just dropping Medicare. Home health agencies. The entire Medicare provider network was fraying at the edges and they are just not going to take—they are going out of business and stopping the provision of Medicare services to Medicare.

So we did two laws since 1997, BBRA and VIPA, plowing the money back to keep the Medicare system from imploding on itself, to keep the beneficiary access going. And so it has been said this morning that IPAB is a back-stop, it is a fail-safe. What it is is, it is political cover for politicians not to have to make the decisions to cut reimbursements to providers. It is like the Base Closing Commission. We didn't make the decision, somebody else did. And that, unfortunately, is where this whole thing is headed. Not just in health care, I would remind you, in other areas of law.

And so here is what we know. Ten thousand baby boomers are retiring every single day today. And a lot less people are following them into the workforce. For those people who had kids in the fifties and sixties, they did a great job. They had a lot of them. But we didn't have as much since then. So we are having about 100 percent increase in the retirement population. But because this is a pay-as-you-go system, current taxpayers pay for current beneficiaries, we only have something like a 17 percent increase in the tax-paying population.

In 2000, 25 percent of Medicare was subsidized with the general fund. We would go out and borrow money in the credit markets to pay for 25 percent of Medicare. Today it is 51 percent. It is going up. And so the problem we have is, not that we don't have the political will to cut costs or reimbursement rates—we don't—but more importantly, we know if we just do price controls we will just deny access. The program will fall in on itself.

So the solution to this problem from our perspective is not to delegate all these decisions to unelected bureaucrats, 15, who just arbitrarily make these decisions, and if we don't like them we have got to have a three-fifths, we have to have a supermajority vote to overturn them and then replace those price controls with other price controls within Medicare somewhere else. The whole thing is designed to take accountability away from politicians, meaning people's elected representatives, and give all this power to 15 people to just do this unilaterally.

But at the end of the day, our conclusion is this won't work because if you are paying a doctor or a hospital, you know, 66 to 33 cents on the dollar for the services they are providing Medicare beneficiaries, they are just not going to provide that service. And so I don't know what you call that, other than rationing, by some other word.

And so what we are saying is we have seen lots of evidence throughout history that choice and competition works. And we have seen lots of evidence throughout history that price controls don't. And so why do we believe in choice and competition? Because it doesn't put 15 bureaucrats in charge. It puts the person in charge. They get to decide.

More importantly, having been on the Ways and Means Committee, overseeing Medicare for 12 years, you don't want a handful of politicians, let alone a handful of bureaucrats who aren't even elected, to play thumbs-up or thumbs-down on what providers can and cannot get for providing services. You want the consumer, the patient, to do that.

More to the point, what we want are the providers of medical services to have an incentive to please us as consumers—to have an incentive to root out waste, fraud and abuse, as they do today, and they root out a heck of a lot more than traditional medical fee-for-service does—to meet our needs.

And since money is finite, and since we have an infinite funding problem with Medicare, our point is this: People who are already on the program, people who are about to retire, a promise was made to them. It is an unfunded promise. It is a promise that at the lowest estimate, it is $31 trillion in the hole, but it is a promise that was made.

Our argument is if we get ahead of this problem now we can keep that promise. If we start turning the curve on our fiscal problems, prevent a debt crisis in this country so interest rates don't spike and the 51 percent financing of Medicare from the general fund, which is borrowed money, doesn't go up, we can keep that promise. And so we think we should do that. And we believe if we do that, by getting rid of IPAB, and therefore its price controls, we can keep this promise to current seniors.

But in order to cash-flow that promise and keep our borrowing down, keep our interest rates down so we can afford that promise which currently is unfunded, you have got to change it for the next generation. And the way we should change it for the next generation is let's recognize that there are people in society with needs greater than others. If you are sick, you have greater needs than a healthy person. If you are poor, you have greater needs than a wealthy person. So let's put our money there; $7,800 more, to begin with, for a low-income person, and that grows every year. If you are sick, your payments go up.

It is not a voucher. Everybody likes to say "voucher." Premium support and vouchers are two distinctly different things. A voucher is you get a check in the mail and then you go out and buy something with that check. That is not what we are talking about here. Just like prescription drug benefit. Medicare pre screens a list of plans, just like they do for Federal employees, and you choose your plan that is Medicare-certified and regulated. And then Medicare subsidizes your plan. More if you are poor, more if you are sick, less if you are wealthy. Why? Because wealthy people have more money, so they can afford more out-of-pocket costs.

But more importantly, these providers have to compete against each other for our business. And so if a woman on Medicare doesn't like her plan, she gets to fire that plan and get another one next

year. More importantly, that plan knows it. If they don't make her happy, if they don't give her what they say they would at a competitive price, she will fire them and she will go to their competitor.

That is why Ford is better, because of Chevrolet or because of Toyota. And that is the whole concept here. The problem we have got is we think we can do this on the cheap. We think we can just fix this problem if we politicians wash ourselves of the responsibility and let some distant bureaucrat make the decisions. I have seen it so many times where a constituent will come and complain about what the government is doing to them, and the elected representative says, I wish I could help you but I can't. It is something the bureaucrats do over at the executive branch. That is not what this country was designed to be like. It is not democracy. It is not government by consent of the governed, and it won't work.

And so what we are simply saying is, we don't believe that this works. The other 80 percent of our economy functions on choice, on competition, on price. We want to inject those market fundamentals—transparency on price, transparency on quality, and an economic incentive to act on those things to fix this problem. And so we just have a very difference of opinion.

And Mr. Holtz-Eakin, I just simply want to ask you in closing, if we do the SGR, like we always say we will—and we will, I have no doubt—we will stop doctors from getting cut 29.4 percent this year, and then stop it again next year, because we are in control of it, elected representatives.

If we do that, what will be the general fund transfer to Medicare in the future? Medicare is already being financed, 51 percent of its budget, by floating bonds and borrowing money. If we stop those cuts—because right now Congress can, IPAB doesn't run that right now—what will be the general fund transfer with borrowed money going into the future?

Mr. HOLTZ-EAKIN. Well, I mean we know that just keeping payments level for 10 years is going to cost well over $300 billion at this point. And you know, you are raising that 51 percent, something that is probably going to be closer to 55, 60 percent. I have to do the math to give you the exact answer. I would be happy to do that.

Chairman RYAN. So I just want to ask Ms. Feder, Dr. Feder, you say that we ought to have IPAB for all of health care. Do you believe that we can better sort of organize or plan the health care system if we can put IPAB in charge of the rest of the payment systems for the private market as well? From age 1 to age, you know, to the end of life?

Dr. FEDER. What concerns me, Mr. Chairman, is that it is an assumption that the private sector, when you do your 30 cents on the dollar or 60 cents on the dollar, that that dollar is somehow immutable as to what health care ought to cost. And what we have seen in MedPac documents is that where the private sector, along with Medicare, is actually working with providers to slow cost growth and are adopting policies to slow cost growth, there hospitals are not losing money on Medicare because they have become more efficient. It is where there is not that kind of behavior in the private sector that essentially the private sector costs grow. They offset

whatever is constrained on the Medicare side, and providers continue to operate as they do.

So I am glad, I think you do get me, and what I am saying is that we need to change the incentives for the entire health care system.

Chairman RYAN. I don't think anybody really disagrees with that. So I think the difference here in execution is instead of having one experiment run by the Federal Government, where we are subject to the whims of their decisions by an unelected bureaucracy, why don't we have more than one experiment? Why don't we have a marketplace that is designed to compete for our business? But, more importantly, give people power. Give people power, especially on Medicare, that they can't be denied care when they choose their plan. Give low-income people a lot more money to cover all their out-of-pocket costs, and not as much to higher-income people.

Ms. Turner, let me ask you the final round of this. Where do you think this is going to head if we stick with the current law? What is the world going to look like in 10 to 20 years if we just basically freeze the law in place as it is today, as it is coming into, what is it going to look like?

Ms. TURNER. Mr. McClintock was wondering what people will do. And I think we can look at what happens in Medicare today. People go to emergency rooms to get routine care because they can't find a private physician to see them. And I believe the current MedPac statistics show that the fact that the Congress will continue to do—has continued to do the SGR fix, has allowed access to continue.

But the important thing is that this legislation assumes that deep cuts down to 33 percent of current private payment go into effect, that absolutely is going to have an impact on patient care and patient access to care. And the choice that the chairman has been talking about is really the way to move to a different system. It is really not can we fix this system.

We know Congress has tried everything it can do, and now instead of trying to fix it, we are going to put more restrictions, more bureaucrats in charge of making decisions about payments. And that can only lead to restrictions on access to care, to physicians dropping out of the programs, to people, as we see in Medicaid, as we see in Europe, in Canada, in some provinces, a quarter of citizens can't find a GP, an access physician to see them. They wind up having to go to hospital emergency rooms.

That is what I worry, is that we are going to relegate people to those kinds of access systems that are not the promise they have been given.

Chairman RYAN. Dr. Holtz-Eakin, do you want to jump in?

Mr. HOLTZ-EAKIN. I just simply believe that Grace Marie is too optimistic. That answer presumes that there remains the capacity for the rest of the U.S. budget to transfer to Medicare and Medicaid enormous amounts of resources, and the only fight is over how much of that goes over, and thus how much turns into increased budget costs versus restricted access. That is not going to be true.

We know the projections for the overall budget, and we know that when they hit a certain point, the underlying 80 percent of the economy from which the health care sector is now drawing all of

its money is going to collapse. And so we have a problem that is bigger than just a genuine and serious problem with beneficiary access to care. We have a problem that mutates past that to being a fundamental threat to our economy. And so the choices that will be made in the future, if we don't change direction now, will not be the choices we make. It will be the bankers' decisions on how this all gets run. And that is not a future we should tolerate.

Chairman RYAN. Well, thank you very much. I appreciate the indulgence and appreciate everybody's time. This concludes our hearing.

[Questions submitted for the record from Mr. Huelskamp follows:]

QUESTIONS SUBMITTED FOR THE RECORD BY HON. TIM HUELSKAMP, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

THE HONORABLE KATHLEEN SEBELIUS, SECRETARY, HEALTH AND HUMAN SERVICES

1. Has the HHS been asked to provide any estimates to the White House on savings that could come as a result of changes to Medicare, or other programs under your Department for the ongoing negotiations on the debt limit?

2. The now Minority Leader Pelosi said last year that we needed to pass the health care bill to see what is in it. One of the things we found out was in it were waivers. On June 2, I sent a letter to you, along with 31 other Members of Congress, requesting information regarding waivers and adjustments for the Affordable Care Act. How many Annual Limit Waivers are currently pending and where are the companies located? How many State Innovation Waivers and Medical Loss Ratio adjustments have been approved, denied, or are still pending? What other types of waivers or adjustments to the Affordable Care Act have been approved, denied or are pending? Why has Nancy Pelosi's district received more waivers than any other district in the country? Can I ever expect to see a detailed, written response? Is this the level of transparency we could expect from IPAB?

3. Because IPAB decisions are not subject to administrative review, does that mean that Medicare patients who may be denied care because of an IPAB reimbursement decision in the future have no access to the federal grievance process?

4. Because IPAB decisions are not subject to judicial review, how could a patient denied care by an IPAB reimbursement decision bring a medical malpractice claim against the Board?

5. Do you agree with OMB Director Peter Orzag who said that IPAB represents the "greatest transfer of sovereignty" from Congress to the Executive Branch in memory? If not, is there a Senate-confirmed body that has equivalent power?

6. On a bi-partisan basis, experts agree that Medicare as we know it cannot continue without massive reforms or cuts. Currently, the administration's plan for the system is implementing IPAB on top of $500 billion in provider cuts. What other ideas for reform, other than restricting access to care by cutting provider payments does the President have? At what level of payment cuts does the administration believe enough providers will no longer accept Medicare patients to create Canadian style waiting lists for routine care?

7. Assuming you are still HHS Secretary when IPAB submits its first draft report to you for your review, what will your priorities and criteria be in reviewing the report? In other words, are there specific cuts would you prefer or expect, and what type of cuts would you reject?

8. Can you explain how we can expect IPAB to correctly assess reimbursement decisions for roughly 7,000 medical services provided by physicians and what criteria will they use in making those decisions?

SECRETARY SEBELIUS' RESPONSE TO QUESTIONS SUBMITTED FOR THE RECORD

THE HONORABLE TODD HUELSKAMP

1. Has the HHS been asked to provide any estimates to the White House on savings that could come as a result of changes to Medicare, or other programs under your Department for the ongoing negotiations on the debt limit?

Answer: HHS is a part of the Administration and fully supports the President's agenda, and in that role, provides proposals and technical guidance to the White House on a variety of topics.

2. The now Minority Leader Pelosi said last year that we needed to pass the health care bill to see what is in it. One of the things we found out was in it were waivers. On June 2, I sent a letter to you, along with 31 other Members of Congress, requesting information regarding waivers and adjustments for the Affordable Care Act. How many Annual Limit Waivers are currently pending and where are the companies located? How many State Innovation Waivers and Medical Loss Ratio adjustments have been approved, denied, or are still pending? What other types of waivers or adjustments to the Affordable Care Act have been approved, denied or are pending? Why has Nancy Pelosi's district received more waivers than any other district in the country? Can I ever expect to see a detailed, written response? Is this the level of transparency we could expect from IPAB?

Answer: A written response to your June 2 letter was sent on July 13, 2011.

CMS posts all approved annual limit waiver recipients and denied applicants on its website, at:

http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

While the location of each applicant is publicly available, it is important to note that the city and state correspond only to the address stated on the application and may not reflect the location of the applicant's enrollees. As of the end of June 2011, a total of 1,471 one-year waivers have been granted. The number of enrollees in plans with annual limits waivers is 3.2 million, representing only about 2 percent of all Americans who have private health insurance today. Sixty-nine applicants were denied waivers.

Section 2718 of the Public Health Service Act, as amended by section 1001 of the Affordable Care Act allows the Secretary to adjust the medical loss ratio (MLR) standard for a State if it is determined that meeting the 80% MLR standard may destabilize the individual insurance market. CMS has implemented a fully transparent process for the State MLR adjustment application. Each applicant submits materials to CMS and the materials are posted to the website. Public comment is then taken. The decision whether or not to grant an adjustment, and the level of that adjustment, is based on the unique circumstances of each state's market and the standards outlined in regulations and guidance. All pending adjustments, final determinations and supporting documentation are posted here: *http://cciio.cms.gov/programs/marketreforms/mlr/index.html.* As of July 12, 2011, 12 States and one Territory had requested MLR adjustments and CMS had issued final determinations for three of those applications. CMS granted adjustments for the three States for which final determinations were issued.

Finally, section 1332 of the Affordable Care Act allows States to apply for a State Innovation Waiver for plan years beginning on or after January 1, 2017. These State strategies would need to provide affordable insurance coverage to at least as many residents as without the waiver and must not increase the Federal deficit. Although these waivers cannot take effect prior to 2017, the Affordable Care Act requires the Secretary to publish regulations codifying this provision well in advance of its effective date. A proposed rule was published on March 10, 2011 with 60 day public comment. Additionally, in his Plan for Economic Growth and Development, the President proposed that State Innovation Waivers be made available starting in 2014, three years earlier than under current law. To date, no State has submitted a State Innovation Waiver request.

3. Because IPAB decisions are not subject to administrative review, does that mean that Medicare patients who may be denied care because of an IPAB reimbursement decision in the future have no access to the federal grievance process?

Answer: IPAB is expressly prohibited from making proposals that would ration health care, raise revenues or Medicare beneficiary premiums, increase beneficiary cost sharing (including deductibles, coinsurance, and co-payments), or otherwise restrict benefits or modify eligibility criteria. We do not believe the statute precludes judicial review of HHS's implementation of an IPAB recommendation that is clearly outside the authority conferred by the statute.

This view is consistent with existing case law.1 Thus, while we cannot offer advice on hypothetical cases, we believe such case law could support a legal challenge to an implemented IPAB recommendation that clearly violated one or more of the statutory restrictions set forth above (such as a recommendation to increase beneficiary co-payment amounts), assuming Congress were to fail to override that recommendation. Of course, we don't have any reason to believe that IPAB will issue rec-

ommendations exceeding its statutory authority, and Congress could exercise its authority to preempt or override an unlawful recommendation, making a legal challenge unnecessary.

1 See, e.g., Hanauer v. Reich, 82 F.3d 1304, 1307 (4th Cir. 1996) ("[E]ven when the statutory language bars judicial review, courts have recognized that an implicit and narrow exception to the bar on judicial review exists for claims that the agency exceeded the scope of its delegated authority or violated a clear statutory mandate."); Griffith v. Fed. Labor Relations Auth., 842 F.2d 487, 492 (D.C. Cir. 1988) ("Even where Congress is understood generally to have precluded review, the Supreme Court has found an implicit but narrow exception, closely paralleling the historic origins of judicial review for agency actions in excess of jurisdiction.").

4. Because IPAB decisions are not subject to judicial review, how could a patient denied care by an IPAB reimbursement decision bring a medical malpractice claim against the Board?

Answer: As stated above, while we cannot offer advice on hypothetical cases, we do not believe the statute precludes judicial review of HHS's implementation of an IPAB recommendation that is clearly outside the authority conferred by the statute.

5. Do you agree with OMB Director Peter Orzag who said that IPAB represents the "greatest transfer of sovereignty" from Congress to the Executive Branch in memory? If not, is there a Senate-confirmed body that has equivalent power?

Answer: Based on new resources and authorities provided to the Department in the Affordable Care Act, the Administration is pursuing unprecedented efforts to protect Medicare, crack down on fraud and abuse, improve the quality of care seniors receive, and constrain the growth in unsustainable health care costs. However, the future of Medicare requires continued vigilance and careful oversight, which is why IPAB was created as a backstop mechanism to ensure Medicare remains solvent for years to come and the IPAB, to the extent feasible, is charged with including recommendations that improve health care while lowering the growth in Medicare spending.

The Medicare Actuary predicts that the IPAB will serve mainly as a backstop as he estimates per capita growth rate in Medicare at or near the target growth rate. The IPAB backstop means that if Medicare spending growth exceeds certain benchmarks, the IPAB will make specific recommendations, and Congress will then have the opportunity to take action. If Congress rejects IPAB recommendations, it will replace them with reforms that achieve the same level of savings. The Board's recommendations will go into effect only if Congress accepts them, or if Congress fails to act. In other words, the IPAB recommendations are implemented only when excessive spending growth is not addressed, and other actions being taken are insufficient to decrease spending to certain targeted levels. Congress fully retains all of its legislative prerogatives to enact alternate proposals.

6. On a bi-partisan basis, experts agree that Medicare as we know it cannot continue without massive reforms or cuts. Currently, the administration's plan for the system is implementing IPAB on top of $500 billion in provider cuts. What other ideas for reform, other than restricting access to care by cutting provider payments does the President have? At what level of payment cuts does the administration believe enough providers will no longer accept Medicare patients to create Canadian style waiting lists for routine care?

Answer: Many of the President's ideas to preserve and strengthen Medicare were contained in the Affordable Care Act. 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, producing savings for the taxpayers and prolonging the life of the Medicare Hospital Insurance Trust Fund until 2024.

The Centers for Medicare & Medicaid Services (CMS) has already implemented many of the savings provisions contained in the Affordable Care Act. These provisions include plans to link hospital payments to quality measures as part of the Hospital Value-Based Purchasing program. Through the Partnership for Patients initiative, CMS is bringing together the public and private sectors to reduce hospital-acquired conditions and preventable hospital readmissions. Further, 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. The Innovation Center is pursuing a number of new initiatives and demonstrations to achieve these goals, including Accountable Care Organizations, bundling payments to promote efficient and quality care, and improving primary care through the Comprehensive Primary Care Initiative and the Federally Qualified Health Cen-

ter Advanced Primary Care Practice Demonstration. 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.

While the Affordable Care Act represents an historic step toward getting health care costs under control, there is still more that we can do to realize efficiencies, cut waste, and improve Federal health care programs. For that reason, as part of the Plan for Economic Growth and Development, the President proposed making changes that would further extend Medicare's solvency by encouraging high-quality, efficient health care and addressing wasteful spending. The new proposals would make changes to Medicare that are gradual, protect current and middle-class beneficiaries, and strengthen Medicare overall. These proposals would save about $224 billion over 10 years by better aligning payments with the costs of care and improving providers' payment incentives to provide high quality care. The proposals also make structural changes that include reducing Federal subsidies for high-income beneficiaries and creating financial incentives for newly eligible beneficiaries to seek high-value health care services to achieve an additional $24 billion in savings.

7. Assuming you are still HHS Secretary when IPAB submits its first draft report to you for your review, what will your priorities and criteria be in reviewing the report? In other words, are there specific cuts would you prefer or expect, and what type of cuts would you reject?

Answer: IPAB's statutory direction is clear: Make recommendations to Congress that, to the extent feasible, will improve care for seniors while lowering the growth in Medicare spending per beneficiary. IPAB is also directed to consider several other factors, including protecting access to necessary and evidence-based services, and also including: care provided in rural areas; the unique needs of those dually-eligible for Medicare and Medicaid; and the effects of its proposals on providers with negative margins. I expect the IPAB to consider all of these factors and will review the specific proposals to ensure they are consistent with Congressional intent.

8. Can you explain how we can expect IPAB to correctly assess reimbursement decisions for roughly 7,000 medical services provided by physicians and what criteria will they use in making those decisions?

Answer: As stated above, the independent physicians, other health professionals, and other experts that serve on IPAB will have discretion in recommending proposals that improve the quality of care for Medicare beneficiaries while slowing the rate of growth of program expenditures. There is no requirement that IPAB review, assess, or make recommendations regarding any one area of program spending, including medical services provided by physicians. Congress was clear in its direction to IPAB, and I expect they will use those criteria to guide their priorities and recommendations.

[An additional submission of Mr. Van Hollen follows:]

Honorable Chris Van Hollen, Ranking Democrat
House Budget Committee
"Medicare's Future: An Examination of the Independent Payment Advisory Board"
July 12, 2011

Insert for the Record

Medicare Payment Advisory Commission
Report to the Congress
Medicare Payment Policy
March 2011
Pages 75-77

for improving care quality and efficiency. Another set of providers to consider for exemption from SGR updates might be medical practices that qualify as medical homes—providing full care coordination and other patient services. The Commission has also explored policies that identify providers whose Medicare expenditures are outliers compared to peers in their specialty. In general, these exemption options can provide improved accountability, relative to the current SGR, but would affect varying—and in many cases small—numbers of physicians.

Broader expenditure target

In our 2007 report examining SGR alternatives, the Commission explored the concept of a broad expenditure target encompassing all of FFS Medicare. Broader expenditure targets would allow for more flexibility in setting targets among different settings, provider types, and categories of services. In doing so, expenditure targets would not be borne solely by physicians. However, a broader expenditure target also carries many of the same risks as the current SGR system—namely, being too removed from individual providers to create appropriate incentives for efficiency.

The Commission plans to continue discussing SGR payment policies in its upcoming work and to consider various approaches for updating payments for physician and other health professional services.

Are Medicare payments adequate in 2011?

Our analysis of payments for physician services in FFS Medicare shows that, in the aggregate, current payments are adequate. Our assessment examines several indicators: beneficiary access to physician care, including rates of physicians participating with Medicare and taking assignment, and changes in the volume of services provided, quality of care, and Medicare reimbursement levels compared with those in the private sector. In the most recent years for which we have data, each indicator was positive or stable with respect to payment adequacy. Unlike our payment adequacy assessments of other providers, such as hospitals, we cannot look at financial performance of physicians directly because they are not required to report their costs to Medicare.

Beneficiaries' access to care: Generally good with relatively few problems reported

Physicians are often the most important link between Medicare beneficiaries and the health care delivery system. Our analysis of the 2008 Medicare Current Beneficiary Survey shows that about 85 percent of noninstitutionalized FFS beneficiaries report that a doctor's office or clinic is their usual source of care. Beneficiary access to physicians, therefore, is an important indicator to monitor when assessing Medicare's payment adequacy. Our analysis of access to physician services focused on indicators from several sources, including patient surveys, physician surveys, beneficiary focus groups, physician focus groups, and claims data.

2010 patient survey shows that, overall, access is good, but primary care continues to be a concern

To obtain the most current access measures possible, the Commission sponsors a telephone survey each year of a nationally representative, random sample of two groups of people: Medicare beneficiaries age 65 years or older and privately insured individuals age 50 to 64. The overall sample size is 4,000 in each group (totaling 8,000 completed interviews, including an oversample of minority respondents).[2] By surveying both groups of people—privately insured individuals and Medicare beneficiaries—we can assess the extent to which access problems, such as delays in scheduling an appointment and difficulty finding a new physician, are unique to the Medicare population.[3]

Results from our 2010 survey indicate that most beneficiaries have reliable access to physician services, with most reporting few or no access problems. Most beneficiaries are able to schedule timely medical appointments and find a new physician when needed, but some beneficiaries experience problems, particularly when they are looking for a primary care physician. Medicare beneficiaries reported similar or better access than privately insured individuals age 50 to 64.

On a national level, this survey does not find widespread physician access problems, but certain market areas may be experiencing more access problems than others due to factors unrelated to Medicare—or even private—payment rates, such as relatively rapid population growth. Moreover, although the share of beneficiaries reporting major problems finding a primary care physician is small, this issue is a serious concern not only to the beneficiaries who are personally affected but also—on a larger scale—for the functioning of our health care

delivery system. The Patient Protection and Affordable Care Act of 2010 (PPACA) contains several provisions to enhance access to primary care, including increasing Medicare payments for primary care services provided by primary care practitioners. This policy marks an important step toward ensuring access, but more levers should be explored. Regulatory changes have also resulted in some payment increases for services that primary care providers frequently provide. The Commission will continue examining multiple approaches for improving Medicare's payment policies to promote primary care.

Most beneficiaries report timely appointments

Because most Medicare beneficiaries have one or more doctor appointments in a given year, an important access indicator we examine is beneficiaries' ability to schedule timely appointments. In the 2010 survey, among those seeking an appointment, most beneficiaries (75 percent) and most privately insured individuals (72 percent) reported "never" having to wait longer than they wanted for an appointment for routine care (Table 4-1). Another 17 percent of Medicare beneficiaries and 21 percent of privately insured individuals reported that they "sometimes" had to wait longer than they wanted for a routine appointment. The differences between the Medicare and privately insured populations in their "never" and "sometimes" response rates were statistically significant, suggesting that Medicare beneficiaries were more satisfied with the timeliness of their routine care appointments.

As expected, rates for getting timely illness- and injury-related appointments were better than rates for routine care appointments. Among those needing appointments, Medicare beneficiaries were more likely than privately insured individuals to report "never" having problems getting timely illness or injury appointments (83 percent of Medicare beneficiaries and 80 percent of privately insured individuals); 13 percent of Medicare beneficiaries and 15 percent of privately insured individuals reported "sometimes" having to wait longer than they wanted. These differences are statistically significant, suggesting that Medicare beneficiaries were slightly less likely than privately insured individuals to encounter delays for illness and injury appointments.

Beneficiaries' access to appointments in 2010 varied by race, with minorities reporting access problems more frequently than whites (Table 4-2, p. 78). This racial disparity existed for both the Medicare and the privately insured populations but was wider among privately insured patients. For example, among Medicare beneficiaries who sought an appointment, a 2 percentage point difference existed between white and minority beneficiaries reporting never waiting longer than they wanted for routine care appointments. This difference was 7 percentage points among privately insured whites and minorities. The trend was similar for illness and injury appointments. A wider disparity among the privately insured population may reflect variation in private market insurance designs.

Finding disparities in access between whites and minorities has been documented by a large body of research, notably summarized in the Agency for Healthcare Research and Quality's 2008 *National Healthcare Disparities Report*. Although disparities among the Medicare population are generally smaller than in the non-Medicare population, disparities related to race, ethnicity, and socioeconomic status remain a factor in beneficiary access to care (Agency for Healthcare Research and Quality 2008, Institute of Medicine 2002, Reschovsky and O'Malley 2008, Williams et al. 2004).

In addition to the ease of scheduling appointments, our survey also asks about respondents' ability to find a new physician if they are seeking one. As in previous years, relatively few survey respondents reported that they tried to find a new primary care physician or specialist in the past year. This finding suggests that most respondents were either satisfied with their current physician or did not have a health event that made them search for a new one. Specifically, 7 percent of Medicare beneficiaries and 7 percent of privately insured individuals reported that they looked for a new primary care physician in the preceding year; a larger percentage (13 percent of Medicare beneficiaries and 15 percent of privately insured individuals) reported seeking a new specialist (not shown in table).

Finding a primary care physician appeared to be more difficult for privately insured individuals than for Medicare beneficiaries. Specifically, among the small share of people (7 percent in each insurance group) who looked for a new primary care physician in the past year, 79 percent of Medicare beneficiaries and 69 percent of privately insured individuals reported that they had no problem finding one. This difference is statistically significant.

Among the 7 percent of Medicare beneficiaries who sought a new primary care physician, 20 percent reported a problem, compared with 31 percent for the privately insured. Of the patients reporting a problem, 8 percent of Medicare beneficiaries characterized their problems

TABLE 4–1

Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2007–2010

	Medicare (age 65 or older)				Private insurance (age 50–64)			
Survey question	**2007**	**2008**	**2009**	**2010**	**2007**	**2008**	**2009**	**2010**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"								
For routine care								
Never	75%*	76%*	77%*	75%*	67%*	69%*	71%*	72%*
Sometimes	18*	17*	17*	17*	24*	24*	22*	21*
Usually	3	3*	2*	3*	4	5*	3*	4*
Always	3	2	2	2	3	2	3	3
For illness or injury								
Never	82*	84*	85*	83*	76*	79*	79*	80*
Sometimes	13*	12*	11*	13*	17*	16*	17*	15*
Usually	3	1	2	2	3	2	2	2
Always	2	1*	1	1*	3	2*	2	2*
Looking for a new primary care physician: "In the past 12 months, have you tried to get a new primary care doctor?"								
Yes	9	6	6	7	10	7	8	7
No	91	93	93	93	90	93	92	93
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor / specialist who would treat you? Was it..."								
Primary care physician								
No problem	70*	71	78	79*	82*	72	71	69*
Small problem	12	10	10	8	7	13	8	12
Big problem	17	18	12*	12	10	13	21*	19
Specialist								
No problem	85	88	88	87*	79	83	84	82*
Small problem	6	7	7	6*	11	9	9	11*
Big problem	9	4	5	5	10	7	7	6
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Percent answering "Yes")	10*	8*	7*	8*	12*	12*	11*	12*

Note: Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in 2007, 3,000 in 2008, and 4,000 in 2009 and 2010. Sample sizes for individual questions varied.
*Statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone survey conducted in 2007, 2008, 2009, and 2010.

[Whereupon, at 1:01 p.m., the committee was adjourned.]

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