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REP. WALLY HERGER HOLDS A HEARING ON MEDICARE PREMIUM SUPPORT PROPOSALS

April 27, 2012 Friday

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TYPE: COMMITTEE HEARING

LOCATION: WASHINGTON, D.C.

COMMITTEE: HOUSE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH

SPEAKER: REP. WALLY HERGER, CHAIRMAN

WITNESSES:

REP. WALLY HERGER, R-CALIF. CHAIRMAN

REP. PETE STARK, D-CALIF. RANKING MEMBER

WITNESSES: FORMER SEN. JOHN BREAUX, D-LA., SENIOR COUNSEL FOR PATTON BOGGS LLP

ALICE RIVLIN, SENIOR FELLOW FOR ECONOMIC STUDIES, BROOKINGS

JOSEPH ANTOS, SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE

HENRY AARON, SENIOR FELLOW IN THE ECONOMIC STUDIES, BROOKINGS

REP. PAUL D. RYAN, R-WIS.

REP. JIM GERLACH, R-PA.

REP. MIKE THOMPSON, D-CALIF.

REP. TOM PRICE, R-GA.

REP. RON KIND, D-WIS.

REP. BILL PASCRELL JR., D-N.J.

TEXT:

HERGER: The subcommittee will come to order.

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

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

Unfortunately, the program faces significant financial challenges and is slated to go bankrupt in 2024. We cannot keep tweaking here and tweaking there, hoping to kick the can down the road for a year or two.

As the Medicare trustees again stated in their annual report, Congress must act sooner rather than later to reform the program to ensure its viability. The Medicare program is in dire need of reform and improvement so that it meets the health care needs of its beneficiaries in the 21st century.

The traditional Medicare benefit was created in 1965, and it really hasn't been reform since, despite the fact that the delivery of health care in the private insurance markets have changed dramatically. The Medicare fee-for-service benefit design, with its array of confusing co-insurance and deductible levels, and its silo delivery system, has not kept pace with the rest of health care.

Can you imagine buying your hospital insurance from one insurance company, your doctor's office insurance from another insurance company, your prescription drug insurance from yet another company, and catastrophic spending protection from a fourth company? That's exactly what the majority of Medicare beneficiaries do today.

This outdated design breeds confusion, waste, and even fraud. Medicare, as an antiquated design, also inhibits care coordination, incentivizes overuse, and has led to financial challenges throughout Medicare's history.

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

Instead, we should examine reforms that will protect and improve the Medicare program. The premium support is one way to do that.

Since the term "premium support" was coined by Henry Aaron, one of our witnesses here today, and Robert Reischauer, both Democrats, it has received a bipartisan support. Moving to a premium support model was advanced by the National Bipartisan Commission on the Future of Medicare, which was co-chaired by Democrat Senator Breaux, another witness here today. Writing in support of the proposal, Senator Breaux and former Ways and Means chairman Bill Thomas, stated that they believed Medicare, quote, "can be more secure only by focusing the

government's powers on insuring comprehensive coverage at an affordable price, rather than continuing the inefficiency, inequity and inadequacy of the current Medicare program," closed quote.

Premium support was also a key component of the recommendation from the Bipartisan Policy Center, co-chaired by Senator Pete Domenici, and former CBO director and Clinton administration OMB director, Alice Rivlin, who's also testifying today. It is in this vein that the 2013 House budget includes a premium support proposal. We have drawn upon the ideas that our witnesses have proposed over the past two decades and put forward a plan to protect Medicare for future generations.

There certainly will be different opinions about how a premium support proposal should work. That is a healthy discussion. However, simply hiding our head in the sand is not. House Republicans have made it abundantly clear that we will not simply watch Medicare become insolvent.

My friends on the other side may not like our proposal to protect the Medicare program, but where is yours? Relying on \$14 billion in savings from so-called delivery reforms and the health care law is not going to save the program. They're already built into the Medicare trustees' estimates that predict Medicare's demise in just over 10 years.

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

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

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

STARK: I'd like to thank Chairman Herger for holding this meeting. I think it's the first hearing the Republicans have held in the Ways and Means Committee to advance their plan to end Medicare as we know it.

Basically, Republicans want to take away Medicare's guaranteed benefits and replace it with a voucher and put the insurance companies back in charge. I don't like their plan. I appreciate their honesty in flying their flag to dismantle Medicare high and proud.

This year, they've modified their plan by saying that traditional Medicare would remain an option. That promise isn't worth very much. Traditional Medicare might be theoretically available, but would be out of reach of many because the voucher would not be guaranteed to cover costs. Traditional Medicare would undoubtedly attract sicker patients and quickly enter into an (inaudible) or into a death spiral.

My Republican colleagues don't like the sound of "voucher" to describe their plan, so they've made up a new term called "premium support." They also dislike being the sole owners of this plan, so they're holding this hearing today. They want to share the blame, and they're trying to

overshadow the fact that every single Democrat in the House of Representatives voted against their budget, which includes their Medicare voucher proposal.

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

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

Instead, they would return us to a time when private health insurers would control what care seniors get and what price they're forced to pay. The CBO has said it would lead to an increase in overall national health spending, as seniors and people with disabilities are moved into less efficient, more costly private plans. It simply takes us in the wrong direction.

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

With that, I look forward to hearing from our witnesses today.

Thank you, Mr. Chairman.

HERGER: Thank you.

Today, we're joined by four witnesses, former Senator John Breaux, who chaired the 1999 National Bipartisan Commission on the Future of Medicare; Alice Rivlin, a senior fellow at the Brookings Institution and co-chair of the Bipartisan Policy Center's Task Force on Debt Reduction; Joe Antos, and (sic) William H. Taylor scholar -- the William H. Taylor scholar at American Enterprise Institute; and Henry Aaron, a senior fellow at the Brookings Institution.

You'll each have five minutes to present your oral testimony. Your entire written statement will be made a part of the record.

Senator Breaux, you're now recognized for five minutes.

BREAUX: Thank you very much, Mr. Herger, for inviting me.

Ranking Member Pete Stark, he and I have been involved in this for many, many, many years. Thank you all for inviting me.

Jim McDermott, who served with me in a great capacity when we had the National Bipartisan

Commission on Medicare Reform, and many of you who I've had the privilege of working with in different capacities, thank all of you for inviting me to talk about one of the most important issues, and, at the same time, one of the most divisive issues that either party is going to have to face, and that is, what do we do with Medicare reform?

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

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

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

On the other, the private sector needs to be involved. The private sector can create competition among competing plans. Government doesn't create competition, private sector can do that.

Secondly, private sector can bring innovation and new products to the market. Government doesn't do that very well.

And third, the private sector can deliver beneficiaries' choices to allow them to select best plan for themselves and their families.

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

A former colleague of mine in the United States Senate was Harris Wofford, a great guy from Pennsylvania. He was a truly committed liberal who served with great distinction in the Kennedy administration, as well as in the Senate.

He argued very strongly that American citizens should have access to the same quality health care that his or her member of Congress had. He argued that if it was good enough for members of Congress, it should be good enough for all Americans.

Now, what each of you have, and your staffs, and millions of other federal employees, and myself included as a retired federal employee, is a health plan that does combine the best of what government can do with the best of what the private sector can do. The Federal Employees Health Benefit Plan enacted in 1959 required that the federal government write the regulations that set up the program and then phase (ph) up to 75 percent of the cost of the health benefits. The beneficiary then pays the rest based on a formula set by law.

Over 350 private health plans are offered under the program, and 14 or so are fee-for-service, and the remainder of what are called premium support plans. Premium support plans have the government paying the 75 percent, and they approve a -- the government does -- approves a group of private plans that employees can choose from that are required by our government to deliver the services, and all of this is implemented by the Office of Personnel Management.

When I chaired the National Bipartisan Commission on the Future of Medicare back in 1988, 1999, we examined several options on how to improve Medicare. No one, Republican or Democrat on that commission, wanted to end the federal Medicare, and a strong majority, 10 of the 17, supported a new delivery system based on a market-based premium support system, where, for most seniors, the premium support would be set at about 88 percent of the standard plan.

Unfortunately, the statute created out of our commission did not require a majority to report, but a supermajority, so our commission's plan was never formally submitted to the president, nor to Congress. However, what happened next was that then-Republican Leader Bill Frist and I developed complete statutory language. Not an outline, not just a print, not just talking points, but complete statutory legislation, and Introduced S-1895, which incorporated the fundamental principles of the Medicare commission proposal.

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

The contribution amount by the federal government would be based -- and this is important -- on the national average of the premiums for a standard benefit package, weighted by plan enrollment and adjusted for risk and for geography, not some arbitrary growth rate like GDP. That standard benefit package would be all services guaranteed under the existing Medicare statute, part of the legislation.

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

And finally, we established a Medicare board. And this board would oversee competition among private and government-sponsored fee- for-service plans and would be the equivalent of the Office of Personnel Management, which today manages the FEHBP program.

It would exercise its authority by regulation and negotiate with the plans. Overall, the commission estimated the proposal would reduce the Medicare growth rate by 12 percent.

One might ask the question, why tamper with Medicare at all? Why change the system that has worked well for 47 years?

Well, I used to drive a 1965 Chevy II. I really loved that car, but I would hate to be driving it today, 47 years later, and keeping up with the maintenance of that car. And I think none of you would want to do the same thing.

Perhaps better answer, however, to that question of why tinker with it now is a statement made by Rick Foster, who, of course, is a chief actuary for the Medicare & Medicaid Services, just this past week. Mr. Foster said in the 2012 trustees report on Medicare, quote, "Without unprecedented changes in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services are very likely to fall increasingly short of the cost of providing these services," unquote.

Some good news out there now is that in addition to the important changes made in the Affordable Health Care Act, Obamacare, made to those under 65 in the private insurance market through exchanges and other things, it also included promising reforms, moving away from traditional fee-for-service Medicare, but still under the fee-for-service program, things like value-based purchasing and bundled payment systems, where CMS will try to realign incentives and reimburse doctors and hospitals for the quality of the care they provide, and not just the quantity.

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

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

(CROSSTALK)

(UNKNOWN): Senator, if you could summarize --

BREAUX: I am summarizing. Last paragraph.

(UNKNOWN): Yes.

BREAUX: I used to say that all the time, and it never stopped.

(LAUGHTER)

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

1965, a bipartisan Congress said that fee-for-service was the best delivery system back then. Let

me suggest that in 2012, the best delivery system is -- was still what is contained in the Breaux-Frist proposal.

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

HERGER: Thank you, Senator.

Ms. Rivlin, you're recognized for five minutes.

RIVLIN: Thank you, Chairman Herger and Ranking Member Stark. I'm delighted to have the opportunity to testify on reforming Medicare through a premium support model.

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

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

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

Our proposal would preserve traditional Medicare as the default option for all seniors permanently. It would also offer seniors the opportunity to choose among comprehensive private health plans offered on a regulated exchange.

These plans would be required to cover benefits with at least the same actuarial value as traditional Medicare and would have to accept all applicants, and would received a risk-adjusted annual payment based on the age and health status of their beneficiaries. The regional exchanges would collect and manage the prices and terms of competing plans within a designated region, and the -- those plans would include traditional fee-for-service Medicare, as well as qualified private plans.

The government's contribution would be set by the second lowest plan in the region, subject to their having a sufficient capacity. With more accessible information about costs and patient outcomes, cost-conscious consumer choice will lead the providers to emphasize preventive measures, managed care coordination of people with multiple chronic diseases, and adopt more cost-effective approaches to the delivery of care. However, we don't know in advance what consumer- driven competition will do. So we have introduced, as a fail-safe, which we doubt will be necessary, a cap on per-enrollee government premium contribution over time at the rate of growth of per capita GDP, plus 1 percent.

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

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

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

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

Thank you very much for having -- giving me the opportunity.

HERGER: Thank you very much.

Mr. Antos, you're recognized for five minutes.

ANTOS: Thank you, Chairman Herger and Ranking Member Stark.

Medicare is a vitally important program, but it is living on borrowed time. Medicare's Part A trust fund will be depleted in 2024, as you said, and the program faces \$27 trillion in un-funded liabilities over the next 75 years. With the retirement of 76 million baby boomers over the next two decades, the program will consume an ever-increasing share of the federal budget unless policies are adopted to bend the -- Medicare's costs curve.

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

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

First, should traditional Medicare be offered as a competing plan option under premium support?

I think that's the most reasonable course. Perhaps as many as 57 million beneficiaries will be enrolled in traditional Medicare 10 years from now, which is when most proposals would start competition under premium support.

Traditional Medicare will not disappear when premium support begins, even if we do not allow any new enrollment. Moreover, traditional Medicare is likely to retain a strong hold in rural areas and other markets that are dominated by a few providers. For that reason, we must find ways to reduce unnecessary spending in traditional Medicare in the near term, as well as after premium support is in place.

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

Second, will premium support shift huge new cost to Medicare beneficiaries?

Let's be clear, the Affordable Care Act already shifts costs to beneficiaries. The law imposes unprecedented cuts in provider payment rates to generate \$850 billion in Medicare savings over the next decade.

According to the Medicare actuary, these payment reductions mean that 15 percent of hospitals and other Part A providers would lose money on their Medicare patients by 2019. That figure rises to 25 percent in 2030. Large, across-the-board cuts in provider payment without changing incentives threaten access to care. And that is a real cost to patients that is not reflected in higher premiums.

In contrast, premium support changes the incentives that have driven up Medicare spending. Plans that hope to increase their profit margin need to seek more efficient ways to deliver necessary care, rather than adding another test or procedure. There is plenty of room to improve efficiency in health care, and plans that ignore opportunities to cut costs will lose market share and see their bottom lines shrink.

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

Third, what index should be used to limit the growth of Medicare subsidy?

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

Finally, what other reforms are needed?

We obviously need to modernize Medicare. We need to make the program fairer. We need to reduce unnecessary spending. That means we need better information, clear financial incentives, and a reformed subsidy structure that reinforces rather than undercuts efforts to slow spending.

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

So, in conclusion, there is broad agreement that we need to bend the Medicare cost curve. The argument is only over how to do it.

Premium support is not an academic theory. It has been effective in lowering costs and enhancing value in the Federal Employees Health Benefits Program for the past five decades, and (inaudible) since the 1990s. A well-designed premium support program can take full advantage of market competition to drive out unnecessary spending and increase Medicare's value to beneficiaries.

It's about time we tried it, and I think we can find bipartisan agreement about moving forward.

Thank you.

HERGER: Thank you, Mr. Antos.

Mr. Aaron is recognized for five minutes.

AARON: Thank you, Mr. Herger and Ranking Member Stark.

Also, special greetings to Congressman Price, with whom I've had the privilege of working in the past.

You have my written statement, and it's, I understand, going to be entered into the record.

I'd like to begin with what I think is the central issue that divides those of us who are opposed to the premium support idea from those who are in favor of it.

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

If they don't, who bears the risk of costs rising faster than projections? Under traditional Medicare, those risks are pooled broadly across the population, and over time, across all Americans.

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

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

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

The whole environment of health care policy has been transformed. We wrote in the wake of the failure of the Clinton health reform effort, and at a time when projections of the insolvency of the Medicare trust fund were becoming steadily worse, and were very near term. Both of those elements has changed.

And in particular, the passage of the Affordable Care Act means that we have put in place a key element of the premium support idea for the rest of the population; namely, health insurance exchanges. We're finding those are difficult to implement. They're politically controversial. I think they will succeed, and those problems are solvable.

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

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

The -- we, at the time, said that no premium support plan should move forward until risk adjustment was good enough to discourage competition based on risk selection. At the time, like Alice, we thought oh, well, it's doable, sometime it will happen. Alas, it hasn't happened yet.

A recent study has shown that the risk adjustment algorithm used under Medicare Advantage actually has increased the degree of risk selection that occurs through Medicare Advantage. We're not there yet. When we are, that would be the time to consider whether premium support merits consideration.

And finally, the idea that competition is going to save money, as an economist I really want to believe that. I got my degrees in that, and I was pledged to like markets. I really do.

The evidence to date is not encouraging. The higher costs of Medicare Advantage are not attributable to the extra -- solely to the extra costs -- extra payments that are made to them, nor is it attributable to a selection of patients.

After controlling for all of those factors, Medicare Advantage plans are more expensive than is traditional Medicare. Furthermore, even Part D drug benefits which have come in below cost, have come in below cost by less than other drug spending outside of the Medicare system, has come in below the projections that were made at about the same time.

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

Thank you.

HERGER: Thank you, Mr. Aaron.

Senator Breaux, I think it's important to get this out of the way right at the beginning of this

hearing. Do you think premium support will, quote, "end Medicare as we know it," as some have claimed?

BREAUX: I think the whole debate politically about ending Medicare as we know it, I think we want to change Medicare, we want to keep Medicare. I think we want to improve the delivery system.

I think everybody is committed to having the federal government provide adequate quality health care for our nation's seniors. But we don't have to do it under a delivery system that was formed in 1965.

Just like my Chevy II, things have changed, things have improved. So what our recommendation is, that, keep Medicare, of course. It's a great program. But change the way it's delivered to our nation's seniors so they get a better deal, a better product, at a better price.

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

BREAUX: Yeah. My answer would be yes, but you don't have to take my word for it. Look at the things we've done in the areas where we've implement premium support.

Medicare Part D is a classic premium support system. The government helps pay for it, and they help set it up, but the private sector compete for the right to deliver the product.

It's a -- let me suggest, it's a program that is more popular today than the Congress that wrote it. And I include myself in that group, because I was there. The seniors love it.

Secondly, the second example is even better. Every one of us up there, and me, have a premium support, Federal Employees Health Benefit Plan. That is a classic premium support.

People can choose from -- they can continue fee-for-service if you want to stay there, but the federal government sets up a premium support. We have the Office of Personnel Management guaranteeing that everybody participates can deliver the project and negotiate for the price. That combines the best of what government can do with the best of what the private sector can do.

So don't take my word. Look at the two times we were able to do this, and I would think you would agree it works very well.

HERGER: Mr. Antos, I think it's important for all of us to focus on what the Medicare program is facing today. The Medicare trustees released their 2012 report just this week.

When do you expect the Medicare hospital insurance trust fund to go bankrupt?

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

HERGER: So by the -- even with the projections that we were to make these major cuts, which most doubt very much we would make to hospitals, what was the bankruptcy -- you say 2024. What was the bankruptcy date in last year's trustees report?

ANTOS: 2024. So we've -- some people say that we've held our ground. Another way to look at it is we're one year closer.

HERGER: In other words, we're one year closer, as you mentioned, to this looming -- addressing this looming problem.

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

Do you agree with this assessment?

ANTOS: Yes, sir. It's absolutely vital.

HERGER: Ms. Rivlin, the plan you worked on with Senator Domenici is similar to the 2013 House-passed budget, as it has private plans that compete against traditional fee-for-service Medicare. Can you please explain how this competition will control costs not only for the beneficiaries enrolled in the private plans, but also for traditional Medicare?

RIVLIN: Yes.

On a structured exchange where you can really see -- where the consumer can really see what the choices are, the plans that participate would offer their -- their wares, and they would have to agree to take everybody who wanted to join their plan, and to give actuarial-equivalent benefits to fee-for-service Medicare. And they would be competing directly with fee-for-service Medicare.

There are lots of new innovations in how you treat people, including people with chronic diseases. And there's evidence that plans can offer better services and bring down the costs of treating Medicare beneficiaries.

We believe that would happen, and that through the bidding process, the cost of the plans would maybe not come down, but not increase as rapidly as they otherwise would. And that fact that the government contribution would be slowed would be a benefit to everybody, including those in fee-for-service Medicare.

HERGER: In other words, quality could be higher, service could be higher, but the cost could be more efficiently --

(CROSSTALK)

RIVLIN: Yes, we think that would be true. Fee-for-service Medicare would compete and would probably get better over time, because otherwise people would leave it. But there's a lot of evidence that fee-for-service doesn't coordinate care very well.

I'm a Medicare beneficiary. I watch this happening. And the coordination among providers is

terrible. If you're looking at comprehensive, capitated plans whose responsibility is to take care of everybody in the plan, you're likely to get better results.

HERGER: Thank you very much.

Mr. Stark is now recognized for five minutes.

STARK: Thank you, Mr. Chairman.

Mr. Aaron, would the Medicare trust fund become insolvent sooner under the Republican plan to repeal ACA?

AARON: The ACA contain many provisions that extend the life of the Medicare trust fund. It was a major improvement in the financial status.

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

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

HERGER: Without objection.

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

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

STARK: Yeah.

AARON: Can I inject one comment which I think is important?

STARK: Please.

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

STARK: You're right. I remember --

(CROSSTALK)

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

STARK: I've always suspected it was Republicans, but, you know, these guys who march outside with billboards over saying that the world is going to come to an end? They've now crossed that out and say that Medicare is going to come to an end in 2024, or whatever, 12 years.

I can remember when those signs said it was going to end in one year, and I can remember years when the trustees' report said we had 20 years. But the fact is that to change the existence, the life of Medicare costs relatively so little to the population at large.

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

Does that make sense to you?

AARON: Yes, it does, but I would modify it in one direction. I haven't a clue what's going to happen in the health care world in 50 or 75 years. What is science going to produce? What will be the impact on longevity?

In my view, trying to look 50 or 75 years ahead, with respect to health care --

STARK: Right.

AARON: -- pensions are different -- with respect to health care, in my view, is a fool's game. And it was a bad day when the actuaries were required to look 75 years ahead in the case of health care.

Looked 25 years ahead. That's quite a long time, and there's a lot of uncertainty within that.

Over that period, you could close the Part A trust fund gap with an increase in payroll taxes of .35 percent each on workers and employers, or more cost sharing on some Medicare beneficiaries, or additional payment cuts through, one would hope, backed up by improvements in delivery, which is one of the goals of the Affordable Care Act. So I think the idea that Medicare is standing on the brink of a dangerous precipice, for as far ahead as it is reasonable to look, is simply incorrect.

STARK: Thank you. The 75-year target doesn't bother me much, but I'll come back and ask Mr. Herger. He'll find out what it's like.

Thank you, Mr. Chairman.

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

With that, Mr. Ryan is recognized.

RYAN: Thanks, Mr. Chairman.

You know, I hesitate to say this, but Dr. Rivlin, I think I agreed with everything you said in your opening statement. And the reason I hesitate is, every time I say something nice about a Democrat, it gets them in trouble. They get viciously attacked.

So, in light of Mr. Stark's opening statement and comments, I'm considering making really nice comments about you.

(LAUGHTER)

RYAN: Let's see if I direct it over from Alice to you. So I'll be working on that.

Look, there seems to be this attempt to undermine premium support and how it came to be. Let's remember that it started as a Democratic idea.

We have the grandfather of the original idea here, the author in Congress of its last iteration here. And so there is clearly room for the two parties to talk to each other about this issue. If we could just calm down a little bit, we might be able to save this program.

Recently, I worked with Ron Wyden. I know that's a name, I probably got him in trouble right there saying that. Here's what Ron Wyden tells me.

First of all, I think if we want real lasting Medicare reform, in my judgment it does have to be bipartisan. So here's what a Democrat, Ron Wyden, tells me.

He says Democrats can't support a proposal that does not have an ironclad Medicare guarantee. It must maintain traditional fee-for-service as a viable option.

It needs to affordability for the Medicare consumer and protect the low income. It must have the strongest consumer protections for seniors and aggressive risk adjustment to protect the marketplace.

So this is what a Democrat in good standing, a member of the Finance and Budget Committee in the Senate, tells me are sort of essential principles for premium support to move forward. That seems hardly irrational to me. That, to me, strikes me as these are ideas we should talk about with each other, and there's plenty of room for conversation with one another, and we ought to have that conversation.

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

There's one thing, Dr. Rivlin, that you convinced me of from all of our conversations over the

years on this, that we modified our plan for this, and that is competitive bidding. It seems to me a far smarter way to set the rate system.

Give me a quick synopsis of why competitive bidding is superior, what are the attributes to it, and how you propose to set it up with the second lowest plan bid and the like.

RIVLIN: Yes, I think competitive bidding among plans, including fee-for-service Medicare, in a regional exchange -- and by regional, we mean a metropolitan area or a large rural area -- how this would work is the plans would offer their -- their plan and bid on the opportunity to serve Medicare beneficiaries with the same benefits. And the second lowest bid would determine the government contribution.

If you chose the lowest bid plan, you'd get some money back. If you wanted to go higher up the scale, you -- you could. You could choose a more inefficient plan or one that offered additional benefits for higher cost.

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

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

BREAUX: Could I add something just really quick to that Senator -- I mean Congressman Ryan? And that is the point that in some rural areas, you may not have competition.

RIVLIN: Right.

BREAUX: So you have to take steps to protect rural areas where there may not be any competition, and we did that in Breau-Frist by saying that no beneficiary would have to pay more than the current Part B premium for a standard plan. So you can take care of those areas where there may not be sufficient competition to really create a competitive model.

RYAN: Five minutes goes fast. Thank you.

HERGER: Thank you.

Mr. Gerlach is recognized for five minutes.

GERLACH: Thank you, Mr. Chairman.

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

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

premium support plan. Is that correct?

RIVLIN: Yes, I do.

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

RIVLIN: Yes. I wouldn't -- I think there are some differences between the plan put in the budget and -- a budget resolution is just a budget resolution.

GERLACH: Right.

RIVLIN: It isn't -- it isn't a draft of a --

GERLACH: Correct.

RIVLIN: -- of a Medicare law. So it's a bit elliptical. And I would stick with my statement that I support Ryan-Wyden.

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

Is that a typical or rational definition of what a voucher is?

RIVLIN: That's what a voucher means to me, and premium support as we define it is definitely not a voucher.

GERLACH: OK.

RIVLIN: You don't get a check from the government, you get a choice among plans. And the plan gets a risk-adjusted payment, a payment that reflects your age and health condition. And you don't even know what that is as the individual bidder, as the individual beneficiary.

GERLACH: OK.

RIVLIN: That's between the government and the plan.

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

RIVLIN: No, it was not a voucher program.

GERLACH: And the Ryan and Wyden proposal was not a voucher --

RIVLIN: Not as I understand those terms, no.

GERLACH: OK. Thank you so much.

I yield back.

HERGER: Thank you.

Mr. Thompson is recognized.

THOMPSON: Thank you, Mr. Chairman.

And thanks to all the witnesses for being here.

I'm a little heartened, actually, to hear about -- there seems to be a lot of agreement. Everybody agrees we need to fix Medicare, we need to make it work, and so that's -- that's the best news I've heard on this topic for a long time.

I would submit, Mr. Chairman, that it might be helpful as we're looking at this if we had a plan in front of us. We've heard a lot of criticism about Mr. Ryan's plan, we've heard criticism about the Ryan- Wyden plan, we've heard those who are proponents of that suggesting that maybe it's not what the critics say it is.

It would be good if we had a plan, and we could actually see the details of that plan and be able to get down in the weeds and look at it. And until that happens, we're just going to -- maybe spinning our wheels. But I do know a couple things for sure.

I know that as I travel my seven-county district that includes both rural areas, Senator Breaux, as well as urban areas, I hear a lot from the people that I represent about Medicare and what they think about Medicare. And I hear them tell stories juxtaposing the Medicare they have today vis-a-vis what their parents or grandparents had.

And it's clear, and I hear it all the time, they like what they have now with Medicare. They like that.

Now, I hear criticism of Medicare. I hear people say, "Don't cut my benefits," and I also hear people say, "Keep your government hands off my Medicare," which is one that I always kind of chuckle out of, because I guess everyone hadn't gotten the memo yet that Medicare is, in fact, a government program. But I've never heard anybody say, "Please, please, go to a voucher system, do away with my defined benefit program."

So -- and I don't think I'm in the minority there. The Kaiser Family Foundation did polling on this. I think it's 70 percent of the people agree with that.

And I think we really need to keep in perspective the fact that providing health care to seniors and to people with disabilities isn't a huge moneymaker. It's not a huge moneymaker.

And I think that it's important that we note -- and I'm glad Mr. Antos pointed out the fact that -- that he puts great belief and credit in what the trustees say. I want to reiterate what Mr. Stark said. The trustees just said that the accountable (sic) care act lengthens the life of Medicare by eight years.

And they said that if we -- the CBO has said that if we put in place my friend Paul Ryan's

proposal, they project that the total health care spending would grow faster under that proposal. And for the typical 65-year-old, there'd be an increased cost between 50 and 66 percent.

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

AARON: I don't think there's a lot of -- I don't think there's a lot of difference among the four witnesses on the fact that rising health care costs are a problem in this country. They squeeze public budgets, they squeeze private compensation.

For that reason, systemic health care reform is the key to moving ahead. I think there's a serious risk of trying to screw down on the costs of just one element, even a large and significant element such as Medicare, while not attending to the rest of the health care system.

For that reason, I think that the key now, the most important thing to do now, is to move ahead with systemic health care reform. The law of the land is the Affordable Care Act. Nobody, I think, regards that law as perfect in every way.

We're going to learn new things as it is implemented, and we will probably change it down the road. But the first job is to make -- to the best of our ability, to make that system work.

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

THOMPSON: Thank you.

My time's expired. I yield back.

HERGER: I thank the gentleman.

And I'd just like to emphasize that as our witnesses have pointed out, the trust fund is going bankrupt in 2024. The trustees indicated it was going bankrupt in 2024 last year. That means we have one year less than we did a year ago.

So this is something the sooner we begin on a bipartisan manner working on this, and not using, hopefully, scare terms like "voucher" -- I don't know of anyone except a few people on the other side that are using that term. The purpose of this hearing is to talk about premium support which is a bipartisan suggestion on how we might be able to fix the system and preserve it. So I'd just like to make that point.

With that, Mr. Price -- Dr. Price is recognized.

PRICE: Thank you, Mr. Chairman.

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

I also want to thank each of -- each of the panelists. You all have put really a life's work into

many things, but not the least of which is positive suggestions and reforms for our health care system.

As a physician, I can tell you that folks are hurting out there, not just -- not just patients and not just doctors. There are real challenges in the current system that we have.

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

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

The status quo is clearly unacceptable. There are new Medicare patients. We talk about 10,000 folks reaching retirement age or getting on Medicare every single day.

If you're in a community, and you are currently a non-Medicare patient reaching Medicare age tomorrow, and you are currently being seen by a physician who does not see Medicare patients, the challenge that you have in finding a doctor to see you as a Medicare patient is huge. The difficulty of new Medicare patients -- to find a physician seeing new Medicare patients is massive.

The physicians out there are going crazy with this current system. It doesn't make any sense at all, and it's more is and more onerous, more and more difficult to be able to just care for patients.

One out of every three physicians in this country limits the number of Medicare patients that they see, one out of every eight physicians in this country sees no Medicare patients at all. That's not a system that works, so we need to find a positive solution, which is what we've been trying to put -- put forward on our side of the aisle.

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

Is that correct?

RIVLIN: That is correct.

PRICE: And would you expand on that? Tell me why you -- our concern was that if we didn't what we called grandfather the grandfathers, that we would not only take political heat, but the challenge of moving in that direction that quickly would be too great.

Please, help me understand why you think we can move there sooner.

RIVLIN: Because we preserve traditional fee-for-service Medicare as the default option. I mean,

it does grandfather anybody who's in it, and it's a permanent option.

If you reach that age, you're in it unless you opt into -- into something else. And we believe that the changes that would take place in the competitive bidding are substantial challenges, but they could be met by, say, 2018.

We'll have some experience in setting up exchanges under the Affordable Care Act by then. And there's no reason not to start sooner and let everybody have -- have a choice.

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

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

Thank you, Mr. Chairman.

STARK: Would the gentleman yield?

I happen to be a fan of his bill to get rid of this idea that if a physician doesn't take Medicare, they're out of the system for two years, and I join with him in trying to see that we get that changed, because that doesn't help anybody. And you're to be credited for seeing that and trying to change it.

Thank you very much.

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

HERGER: Mr. Kind is recognized.

KIND: Thank you, Mr. Chairman. And thank you for holding this hear.

And I want to thank the witnesses for your testimony here today.

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

And I'm one of those dwindling breeds here, apparently, in Congress these days; a moderate, centrist member of Congress trying to find different pathways forward, hopefully in a bipartisan fashion to address the challenges of our time. And I can't think of a bigger challenge than the

dysfunctional health care system and the impact it's having not only on people's lives, but on our budget and our national finances.

And I've been encouraged listening to a lot of your testimony, because there appears to be a lot of agreement on the panel today that a lot of the tools that we put in place in the Affordable Care Act need time to move forward -- delivery system reform, so we get better, integrated, coordinated care, leading to better outcomes, payment reform so it's value-based, not volume-based. In a lot of respects, this hearing and discussion we're having is premature.

And, Mr. Aaron, I agree. I think the Affordable Care Act needs a chance to move forward to see if this stuff works before you can actually have a serious conversation about a voucher or a premium support plan and who, ultimately, is going to bear that risk. But I've always been interested in just three things when it comes to health care reform: better quality of care, for a better bang for the buck, and making sure that all Americans have access to that type of care in this country.

And how we get there is something that we have to continue to talk about. But one of my concerns with the Republican budget proposal and their voucher or premium proposal is the risk in who's going to bear it. But a bit of a parochial concern that I have from the state of Wisconsin.

We have traditionally, historically, been one of the lowest Medicare reimbursement states in the entire nation. We share that with the Pacific Northwest and some other regions. And under their proposal, apparently, the rates will get locked in at the lower of either the current fee-for-service reimbursement rate or the second lowest plan in that region, which would guarantee in Wisconsin that our providers are locked in at the lowest Medicare reimbursement rate, which they are struggling to live under today, which tells me that they're going to have to continue to cost-shift the inadequacy of Medicare reimbursements onto the backs of businesses large and small..

RYAN: Will the gentleman yield?

KIND: -- onto the backs of private health care plans -- in a second, so I can make my point.

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

And I've tried in my way to work in a bipartisan fashion on this committee. And, Mr. Aaron, you pointed out that it's crucial that these exchanges have a chance to move forward and show whether or not they're viable or not. And I've been the author in previous years of the SHOP Act, which was the basis for these health insurance exchanges, and every year I introduced that proposal I had an equal number of Republicans and Democrats on that bill.

We put it in the Affordable Care Act, and my Republican colleagues ran for the hills. I was one of the authors with Mr. Blumenauer on reimbursing our health care providers for counseling on advanced directives. And every year we introduced that bill, we had at least five or six members of this committee, Republican members, who were on that legislation. That was put into the

Affordable Care Act and that turned into death panels, and my Republican colleagues ran for the hills. So having that bipartisan conversation is difficult to have when you've got principles or issues that we had previously agreed on that suddenly divide us today.

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

I talked to Ron Wyden, too, and sometimes I feel like I'm talking to two different people who are embracing the same type of plan. What Paul understands what the plan would mean and what Ron Wyden understands is sometimes they're talking past each other. So unless or until you put something on paper so that we can truly analyze the impact of what this is going to mean, all this is theoretical.

RYAN: If the gentleman would just yield kindly, I'll send to you and Mr. Thompson the plan that Senator Wyden and I co-authored with our signatures, and I'll send it over to your office.

KIND: Right.

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

Thank you, Mr. Chairman.

Mr. Pascrell is recognized.

PASCRELL: Thank you, Mr. Chairman.

Thank you to the panelists.

I've heard and I've said many times health care reform is entitlement reform. Folks on the other side don't want to hear that.

We haven't touched entitlement reform in the health care bill. I think that is utter nonsense.

One-third of the health care bill is devoted to Medicare and Medicaid. It is very specific about the recommendations, and those are recommendations that we should be considering if we weren't trying to suffocate this legislation before it breathes fully in the next two years.

Not only did -- we're going to reduce costs for Medicare, but, also, the health care act reduce costs for beneficiaries, unless you don't agree with the CBO numbers. The majority's attempt to repeal reform and turn Medicare into -- let's not use a voucher program, let's not use that word, I call it the more out of your own pocket folks program. I think that will hurt beneficiaries.

And there's no doubt about it, this is going to mean more money out of pocket. No one has

denied that. No one.

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

And starting in 2030, by \$8,000 by 2050. You want to talk about the future, let's talk about the future.

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

You're talking about competition, let's increase competition in terms of Medicare. We don't have competition in the health care system. Many states have only two or three companies who write health insurance. Why don't we do something about that?

If we want to foster competition, let's foster competition. We don't really mean it.

This is (inaudible), it's empty. These are words that we use back and forth. This is one-upmanship. That's all we are after.

The basics of health care will be changed by the health care act for the better of Americans. It will not be a socialistic system -- thank God we graduated from that -- since more insurance companies will be involved in order for us to gain favor with the person -- the people that we're dealing with.

This is -- you know, we're heading back to 1964. I am convinced that that's the direction we want to go in, when senior poverty was at the greatest since the Great Depression. That's where we want to go.

Why don't we -- why don't we just say that? We're using a lot of pretty words.

Yeah, you may shake your head, Mr. (inaudible), but I am telling you, we are marking time in place while many seniors are being stopped at the door because they are under Medicare. That's what we should be addressing, that's what we should be saying, enough of this. The health care system is not working.

The health care system has been totally taken over by the insurance -- health insurance companies of this country. You know it and I know it.

We don't have competition. In New Jersey, what do we have, three or four companies that write health insurance? This is competition? What is this competition?

(inaudible) maybe next year we'll have three companies. Maybe company C will take over company D.

How many states do we have only three or four or less companies writing health insurance? And

you want to put our seniors into that situation? That's not competition. That's a joke. You know it and I know it.

By the way, Mr. Aaron, I want to congratulate you on the work you've done. I know since I've been here for 16 years, you've been at the forefront of talking about these issues.

These are critical issues for all of us. I know that it's not very popular to try to hold down out-of-pocket expenses. That's not a popular position, Mr. Aaron. But I don't care whether it is or isn't.

You've done the right thing. I admire what you're doing. We've got enough here to work with within the legislation to change Medicare, but let's not throw away everything because we want to get to a few who will profit only.

Thank you, Mr. Chairman.

HERGER: Dr. Boustany is recognized.

BOUSTANY: Thank you, Mr. Chairman. Thank you for holding this hearing.

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

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

BREAUX: Thank you.

BOUSTANY: Mr. Aaron, you raised a point about competition and the fact that it has not lowered cost. I would submit that we're really stuck right now between a price-controlled system and vastly imperfect competition.

We don't really have the kind of competition that's necessary both in the health care financing arena, as well as in the delivery system aspect of this. And I think if we could get to more perfect competition there, we would see the advantages of lowering costs and enhancing quality. And that's coming from somebody who's had many years practicing in the health care system as a physician.

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

And I know, Senator Breaux, you and I -- actually, even before I got to Congress, back in the '90s -- had serious concerns about trends I was seeing in the Medicare program whereby, for instance, as a heart surgeon, I'd see a patient in the emergency room and do an emergency coronary bypass operation, and then in the aftermath of all that, we couldn't find a primary care physician to take

care of the patient's basic health care needs. And I'd have to get on the phone and start begging -- begging physicians in my community that I knew well and worked with to take on a new patient.

And the whole issue was the cost. The cost of care and the cost to these physician practices is not being met by reimbursement.

And so if we can get to a system that brings us back to a real competition, I think it makes a difference.

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

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

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

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

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

AARON: I agree with you completely, and it's a --

(CROSSTALK)

BOUSTANY: I'd like to --

AARON: -- of how the law may need to be amended.

BOUSTANY: Senator Breaux?

BREAUX: An alternative is that I think that Senator (inaudible) pointed this out. Ryan talked about the demonstration programs that are in the accountable care act. I remember when I was in Congress, when I wanted to stop something from happening, I used to offer an amendment to do a study or maybe to do a demonstration program, hoping it never got completed.

But I think the things that are in the accountable (sic) care act, the demonstration programs are very important. And -- but you can be for both, going to a premium support system and demonstration projects in the accountable (sic) care act.

If the demonstration programs work, it will improve the fee-for- service delivery system. And then, if you have premium support, they will be better competitors.

And that's what we're trying to bring about. I mean, I think the demonstration programs are helpful, they're important, but they're not an either-or situation. You can move to a premium sport system and support the demonstration projects, and hope that they work very well.

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

RIVLIN: Yes. I fully support what Senator Breaux just said.

It's a mistake to think of these as alternatives. At least our plan envisions that the Affordable Care Act continues, that the demonstrations and the various institutions that were set up to improve the delivery system go ahead, and we hope that works. We're only saying there ought to be another way to get these innovations into the use, and that would be competition.

BOUSTANY: Thank you.

Mr. Antos?

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

BOUSTANY: Thank you.

I yield back, Mr. Chairman.

(UNKNOWN): (inaudible)

HERGER: I want to thank our witnesses for your testimony today. This has been an extremely interesting discussion, one that highlights the need for Congress to act soon in order to place Medicare on sound financial footing. Premium support proposals like those we heard about today hold promise to improve how care is delivered, better protect beneficiaries against Medicare's cost-sharing requirements, and utilize competition to control costs for the program as a whole.

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

With that, the subcommittee's adjourned.

END

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