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3 HIF101.140

4 ``STRENGTHENING MEDICARE FOR SENIORS: UNDERSTANDING THE

5 CHALLENGES OF TRADITIONAL MEDICARE'S BENEFIT DESIGN''

6 THURSDAY, APRIL 11, 2013

7 House of Representatives,

8 Subcommittee on Health

9 Committee on Energy and Commerce

10 Washington, D.C.

11 The subcommittee met, pursuant to call, at 10:01 a.m.,
12 in Room 2322 of the Rayburn House Office Building, Hon. Joe
13 Pitts [Chairman of the Subcommittee] presiding.

14 Present: Representatives Pitts, Burgess, Blackburn,
15 Gingrey, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers,
16 Pallone, Dingell, Matheson, Green, Christensen, Sarbanes and

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17 Waxman (ex officio).

18 Staff present: Matt Bravo, Professional Staff Member;
19 Steve Ferrara, Health Fellow; Julie Goon, Health Policy
20 Advisor; Brad Gantz, Policy Coordinator, Oversight and
21 Investigations; Sydne Harwick, Legislative Clerk; Robert
22 Horne, Professional Staff Member, Health; Katie Novaria,
23 Professional Staff Member, Health; John O'Shea, Professional
24 Staff Member, Health; Monica Popp, Professional Staff Member,
25 Health; Andrew Powaleny, Deputy Press Secretary; Heidi
26 Stirrup, Health Policy Coordinator; Phil Barnett, Democratic
27 Staff Director; Alli Corr, Democratic Policy Analyst; Amy
28 Hall, Democratic Senior Professional Staff Member; Elizabeth
29 Letter, Democratic Assistant Press Secretary; Karen
30 Lightfoot, Democratic Communications Director and Senior
31 Policy Advisor; and Karen Nelson, Democratic Deputy Committee
32 Staff Director for Health.

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|
33 Mr. {Pitts.} The time of 10 o'clock having arrived, the
34 subcommittee will come to order. The Chair will recognize
35 himself for an opening statement.

36 Nearly 50 million seniors rely on the Medicare program
37 for their health care. It is important for us to understand
38 Medicare's current benefit structure and look at ways to
39 modernize it to better serve beneficiaries and protect them
40 from catastrophic costs.

41 When it was created in 1965, Medicare's benefit design
42 was modeled on private insurance products available at the
43 time. However, while the private insurance market has
44 undergone dramatic changes in the last half century,
45 Medicare's traditional benefit structure has remained
46 essentially unchanged.

47 Unlike most private insurance today, which has a single
48 deductible for all medical services, Medicare has separate
49 deductibles for Part A, hospital services, and Part B,
50 physician and outpatient services. While the Part A
51 deductible is rather high--\$1,156 in 2012--the Part B
52 deductible is relatively low--- \$140 in 2012.

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53 Medicare fee-for-service also has a complex and
54 sometimes confusing copayment structure. In addition to the
55 Part A deductible, beneficiaries also pay daily copayments
56 for stays at hospitals and skilled nursing facilities.
57 Depending on how many hospital stays a senior incurs in a
58 year, he or she may owe more than one hospital deductible for
59 a year. In addition to the Part B deductible, beneficiaries
60 also pay a monthly Part B premium, and generally pay 20
61 percent of most charges for outpatient and physician
62 services.

63 As Medicare's current benefit structure has no cap on
64 how much out-of-pocket spending a beneficiary can incur,
65 seniors are left open to considerable financial risk and
66 uncertainty. They don't know what they will have to pay when
67 they go in for a procedure or test, and ultimately this
68 uncertainty threatens every senior with the potential of
69 medical bankruptcy. Due to this financial uncertainty, and
70 the lack of comprehensive coverage in fee-for-service, almost
71 90 percent of beneficiaries purchase or receive supplemental
72 insurance.

73 Everything about our health care system has changed

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74 dramatically since the 1960s as health care has become more
75 and more complex. The models and standards of care, tests,
76 treatments, drugs and medical breakthroughs that we enjoy
77 today were unknown when Medicare was enacted. In 1965,
78 insurance protected us against hospital costs from conditions
79 that were most likely fatal--heart disease, cancer and
80 stroke. Today, we use insurance to help manage chronic
81 illnesses and treat diseases, allowing beneficiaries to live
82 for decades and to stay in home and community settings for
83 much longer.

84 The only part of our health care system that has not
85 evolved since Medicare's inception is Medicare's fee-for-
86 service benefit design itself. We don't give our seniors
87 1960s medical care--in many cases that would be considered
88 malpractice today--so why do we continue to give them a 1960s
89 insurance product?

90 We have an obligation to modernize Medicare and
91 standardize its cost-sharing structure. We should have a
92 single deductible for Parts A and B, and we should streamline
93 benefits so that fewer seniors will have to purchase
94 supplemental coverage with money from their own pocket. We

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95 should institute a catastrophic cap on out-of-pocket spending
96 to protect seniors from the threat of medical bankruptcy.
97 And with Medicare's unsustainable financial footing--
98 according to its trustees, Medicare will be insolvent by
99 2024, and as soon as 2017--we need to expand means testing
100 for higher-income beneficiaries, in order to protect the most
101 vulnerable seniors. Let us bring Medicare into the 21st
102 century.

103 I would like to thank MedPAC Chairman Glenn Hackbarth
104 for agreeing to testify today. In recent years, MedPAC has
105 made many recommendations on how to improve the Medicare
106 program, and we are eager to hear about some of them.

107 [The prepared statement of Mr. Pitts follows:]

108 ***** COMMITTEE INSERT *****

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|
109 Mr. {Pitts.} At this point I will recognize the ranking
110 member, Mr. Pallone, for 5 minutes for opening statement.

111 Mr. {Pallone.} Thank you, Chairman Pitts, and I am very
112 pleased that you have decided to consider today's topic.

113 Improving and strengthening Medicare for generations to come
114 is a primary goal of mine. In fact, I have dedicated time to
115 ensure seniors have access to affordable health care options
116 and the safety nets that they need to age with dignity and
117 respect.

118 It is no exaggeration to say that Medicare alone is the
119 most successful health care and anti-poverty program ever,
120 and this is why Medicare should be protected and improved,
121 not left vulnerable to cuts in the years to come.

122 The Affordable Care Act begins those improvements. It
123 reduces Medicare spending, extends solvency and brings growth
124 in per-patient costs to record lows. In addition, preventive
125 services are now free of charge to beneficiaries, and we
126 finally have laid the groundwork to reward treatment value
127 over volume.

128 I believe more can be done, however. The fact is, we

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129 are faced with an inevitable reality that our Nation's baby
130 boomers are aging into the program at very high rates, higher
131 rates than we have seen in the past. In fact, 11,000 new
132 seniors become eligible for Medicare every day. So I think
133 we need to explore the option of modernizing the Medicare
134 benefit design. Right now, some beneficiaries already pay
135 too much out of pocket, and for years, my colleagues and I
136 have explored the need for some type of catastrophic cap for
137 seniors, in addition to the fact that Part A and Part B have
138 such divergent cost sharing and deductibles might seem
139 arbitrary and confusing. Why shouldn't Medicare be more
140 seamless and simple?

141 Given that the average beneficiary makes only \$22,500
142 annually and already spends disproportionately more on health
143 care than a younger person makes this very challenging
144 territory. When you change one side of the ledger, it has an
145 impact on the other side, and any reform must be done without
146 significant cost shifts to seniors.

147 But what Republicans want to do when they talk about
148 reform is to cut the structural foundation of Medicare, turn
149 the whole thing over to insurance companies, and I can tell

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150 you right now that that option is simply a nonstarter. In
151 addition, any proposals must be carefully examined not by how
152 they might save money but how they will benefit
153 beneficiaries, providers and the system as a whole. We can't
154 restructure the program for the sake of generating savings,
155 whether that is in the name of deficit reduction or to help
156 pay for the SGR fix, because that is bad policy. We must
157 modernize the program because it is good for the very real
158 people that it serves and will serve for generations to come.
159 We have to modernize because we recognize that perhaps it is
160 not designed the most efficient or affordable way, and I
161 stand ready to explore those options, but I will not stand by
162 while others lose sight of the importance of Medicare to our
163 Nation's seniors, and I yield back the balance of my time. I
164 don't know if any of my colleagues want time. Then I will
165 yield back the balance of my time.

166 [The prepared statement of Mr. Pallone follows:]

167 ***** COMMITTEE INSERT *****

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|
168 Mr. {Pitts.} The Chair thanks the gentleman and now
169 recognizes the vice chairman of the subcommittee, Dr.
170 Burgess, for 5 minutes for a statement.

171 Dr. {Burgess.} I thank the chairman for the
172 recognition.

173 We have heard it several times this morning already.
174 The 12,000 new beneficiaries added to Medicare every day put
175 pressure on the system and does move it closer towards
176 insolvency. In its current form, Medicare will not be able
177 to meet the promise it has made in a few short years. It is
178 not a surprise. We expect a program designed in 1965 to
179 adapt to the needs and usage pattern of beneficiaries in the
180 21st century. Medicare's current benefit design needs to be
181 reformed in a way that more adequately reflects the needs and
182 expectations of today's seniors.

183 The first step in moving toward a higher-performing
184 Medicare program must be the elimination of the flawed
185 Sustainable Growth Rate formula. Last-minute fixes to the
186 formula certainly have burdened this committee, but it has
187 been devastating to beneficiaries and providers, producing an

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188 unpredictable payment environment and has risked
189 beneficiaries' access to care. Last week, the majority along
190 with the Ways and Means Committee released the second draft
191 of a proposal to repeal or replace the broken Sustainable
192 Growth Rate formula. The proposal realizes that the key to
193 reforming the system is to enable providers to have
194 flexibility to participate in payment and delivery models
195 that best fit their practice.

196 There will always be areas where providers choose or
197 need to practice in a fee-for-service model. We must also
198 continue to seek out innovative models that can adapt to
199 changes in clinical guidelines and best practices, but the
200 heart of the issue remains the beneficiary--the patient. As
201 cost pressures increase, we risk the ability to provide
202 access to services for our patients. We must seek reforms
203 that provide patients with greater control of their health
204 care. If we ask a beneficiary to participate in their health
205 care through cost sharing, we are obligated to provide them
206 with transparent cost information so that they can plan for
207 their future needs. It is hard to plan for what 20 percent
208 coinsurance means when you don't know what 20 percent is part

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209 of. Enabling patients to be more involved in their care not
210 only allows them greater control of their health care
211 spending but provides greater protections for patients and
212 moves an outdated program into the future.

213 We have neglected these problems for far too long. We
214 know the structural and fiscal problems in the health care
215 system. The only question now is how long will Americans
216 tolerate Congress staring at these problems without actually
217 fixing them for future generations.

218 I am very grateful to see Mr. Hackbarth back with us
219 this morning. He has been before our committee several
220 times. MedPAC has recommended a range of different policies
221 over the years to reform Medicare's benefit structure. I
222 certainly look forward to hearing more of these ideas in Mr.
223 Hackbarth's testimony, and I would now like to yield to the
224 gentleman from Georgia, Dr. Gingrey.

225 [The prepared statement of Dr. Burgess follows:]

226 ***** COMMITTEE INSERT *****

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|
227 Dr. {Gingrey.} Mr. Chairman, I thank the vice chairman
228 for yielding to me.

229 As a physician for over 30 years, it was my job to
230 engage with patients and offer them a straight answer no
231 matter the seriousness of the prognosis, and I think at this
232 point it is incredibly important for Congress to do the same
233 thing, to engage seniors on the urgency of Medicare's fiscal
234 situation and work to explain how changes to the current
235 Medicare benefit can decrease personal risk and increase the
236 solvency of the program.

237 I don't think that anyone here would disagree that the
238 Medicare program of today is in trouble. The hospital trust
239 fund is to set to run out somewhere between 2017 and 2024,
240 whoever you believe, but clearly it is coming. What will
241 happen once this point occurs is anybody's guess. The
242 looming fiscal disaster must certainly be addressed before
243 the fund is exhausted lest we leave beneficiaries with
244 unacceptable costs or lack of access to care, or both.

245 Mr. Chairman, we must look for ways to improve the
246 Medicare benefit not only for our current seniors but to

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247 ensure those benefits are there for future generations. We
248 have a system that was created in the 1960s, as Dr. Burgess
249 was just mentioning, very few adjustments since then. The
250 way we practice medicine today has changed, and it is time
251 for the way we pay for medicine to reflect that, and I thank
252 you, Mr. Chairman, for calling this hearing. I look forward,
253 as I know my colleagues do, to hearing from Mr. Hackbarth.
254 He has been with us, as has been said, a number of times, and
255 his suggestions for restructuring the benefits and incentives
256 to improve Medicare for this country's beneficiaries are
257 welcome. So I thank Dr. Burgess, and I will yield back.

258 [The prepared statement of Dr. Gingrey follows:]

259 ***** COMMITTEE INSERT *****

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|
260 Mr. {Pitts.} The Chair thanks the gentleman and now
261 recognizes the ranking member of the full committee, Mr.
262 Waxman, 5 minutes for opening statement.

263 Mr. {Waxman.} Thank you, Mr. Chairman.

264 For more than four decades, Medicare has been a critical
265 program for ensuring the health and the financial well being
266 for senior and disabled people. I appreciate the opportunity
267 to talk about ways we can continue to improve the program by
268 broadening the protections for beneficiaries and improving
269 the value of the program for both beneficiaries and
270 taxpayers.

271 I welcome our witness from MedPAC, Mr. Hackbarth. I
272 appreciate your coming back to our committee. The
273 recognition by MedPAC that we should improve beneficiary
274 benefits by putting a limit on out-of-pocket catastrophic
275 spending, rationalizing deductibles, and making coinsurance
276 and copayments more predictable makes sense, but with any
277 policy, the devil is in the details.

278 The median income for Medicare beneficiaries is only
279 \$22,500 a year. A lot of people think that the elderly are

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280 the wealthiest, and there are wealthy elderly but the median
281 income is \$22,500. Medicare beneficiaries already pay more
282 out of pocket for health care than individuals under 65. So
283 any proposal to redesign Medicare that leaves beneficiaries
284 holding the bag is not one that I could endorse.

285 That is why I am glad to see that a key element of
286 MedPAC's proposal is that it is ``beneficiary liability
287 neutral''. That is, on average, beneficiary out-of-pocket
288 payment should not increase, and at the same time, we need to
289 keep in mind that there will inevitably be winners and losers
290 within the Medicare population.

291 There are other elements of MedPAC's redesign option
292 that I believe need more careful scrutiny. MedPAC also
293 recommends adding a charge for supplemental insurance
294 policies, whether provided by employers or purchased by
295 individuals, to offset the financial impact to Medicare of
296 first-dollar coverage. I think there are two important
297 points to be made here, one, that these are not separate
298 proposals. The proposal to reform supplemental coverage is
299 linked and not severable from improving beneficiary benefits.
300 This is important because I would hate to see some of my

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301 colleagues who are more concerned with cutting costs than
302 securing benefits try to do one without the other. We also
303 need to carefully assess the impact this could have on the
304 near poor, who do not qualify for Medicare extra help for
305 their out-of-pocket costs and may not have the means to
306 afford any additional costs.

307 My second point has to do with the unintended
308 consequences that eliminating first-dollar coverage could
309 have on necessary utilization. The problem is that the
310 relationship between cost sharing and service utilization is
311 not the same in low-income and elderly populations,
312 especially sick, elderly populations, as it is in younger,
313 healthier populations. The Medicare population is older,
314 poorer, with 50 percent of beneficiaries at or below 200
315 percent of the federal poverty level, and sicker, with 40%
316 having three or more chronic conditions, than the general
317 population. As a result, if we make supplemental insurance
318 less affordable or reduce the level of coverage, Medicare
319 beneficiaries are at greater risk of deferring not only
320 unnecessary care, but necessary care, negatively impacting
321 their health.

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322 As we think about opportunities to improve the benefit
323 package in Medicare, we must add protections for
324 beneficiaries and at the same time be careful not to generate
325 both predictable and unintended consequences. We must
326 continue to protect our most vulnerable seniors. Finally, we
327 must make sure that we are not using program redesign as a
328 pretext for reducing spending by shifting costs onto those
329 beneficiaries.

330 Thank you, Mr. Chairman. I yield back the time.

331 [The prepared statement of Mr. Waxman follows:]

332 ***** COMMITTEE INSERT *****

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|
333 Mr. {Pitts.} The Chair thanks the gentleman. That
334 concludes the opening statements of the members.

335 We have one witness today, and our panel today we have
336 Mr. Glenn Hackbarth, Chairman of the Medicare Payment
337 Advisory Commission. Thank you for coming. You will have 5
338 minutes to summarize your testimony, and your full written
339 testimony will be placed in the record. At this point you
340 are recognized for 5 minutes.

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|
341 ^STATEMENT OF GLENN HACKBARTH, J.D., CHAIRMAN, MEDICARE
342 PAYMENT ADVISORY COMMISSION

343 } Mr. {Hackbarth.} Thank you, Chairman Pitts and Ranking
344 Member Pallone and Vice Chairman Burgess and Ranking Member
345 Waxman. I appreciate the opportunity to talk about MedPAC's
346 recommendations on redesigning the Medicare benefit package.

347 In our view, the current Medicare benefit package is
348 both inadequate and confusing. It is inadequate in the sense
349 that it lacks catastrophic coverage, that is, a limit on the
350 maximum out-of-pocket costs that can be incurred by a
351 patient. It is confusing with its bifurcated Part A and B
352 structure and a complex system of patient cost sharing, a
353 mixture of copayments and percentage coinsurance. In our
354 view, the status quo, the current benefit package, is not
355 good for Medicare beneficiaries nor for taxpayers.

356 Because of the inadequate and confusing nature of the
357 Medicare benefit package, many beneficiaries are induced to
358 buy supplemental coverage, often at a very high price.
359 Taxpayers in turn must pay for the increased costs resulting

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360 from supplemental coverage that often covers even the first
361 dollar of out-of-pocket expense. In our view, the principal
362 winners from the status quo are the insurance companies that
363 sell supplemental coverage. It is a lose-lose proposition
364 for Medicare beneficiaries and for taxpayers.

365 With these inadequacies in mind, MedPAC has recommended
366 redesigning the Medicare benefit package consistent with five
367 principles. First, there should be no increase the average
368 Medicare beneficiary liability for out-of-pocket costs. In
369 other words, the benefit package should not be reduced in its
370 actuarial value. We don't believe that Medicare currently is
371 too rich a benefit package. If anything, it is too lean,
372 given the population served. Second, we believe that a
373 redesigned Medicare benefit package should include an out-of-
374 pocket limit, that is catastrophic coverage. Third, we
375 believe that wherever possible, the Medicare benefit package
376 should be simplified, for example, by substituting fixed
377 dollar copays for percentage coinsurance. Our research with
378 beneficiaries shows that fixed dollar copays are much more
379 readily understood and provide some comfort to beneficiaries
380 about what their costs will be for particular services.

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381 Fourth, we believe that Congress should give the Secretary of
382 HHS the authority to modify the Medicare benefit package
383 consistent with the principles of value-based insurance
384 design. That means that the Secretary should have the
385 authority to reduce out-of-pocket payments for beneficiaries
386 for services that are established by scientific evidence to
387 be of high value to patients. Conversely, the Secretary
388 should be able to increase copayments for services that
389 evidence shows are of low value to patients. Finally, we
390 recommend that Congress institute a charge on supplemental
391 coverage. The purpose of the charge would be to ensure that
392 beneficiaries who elect to buy supplemental coverage share at
393 least a portion of the additional costs that that private
394 decision results in for the taxpayers and the Medicare
395 program. The premium that a beneficiary pays for
396 supplemental coverage only covers a fraction of the
397 additional costs that the program incurs as a result of
398 supplemental coverage.

399 Let me conclude with three points that I think bear
400 particular emphasis. One is that patient cost sharing is an
401 imperfect method of controlling costs, albeit a necessary one

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402 in the context of a free choice of provider, largely fee-for-
403 service insurance program. We don't believe that patient
404 cost sharing should be the only or even the principal method
405 of trying to control costs. Indeed, most of MedPAC's work
406 focuses on changing how we pay providers, providing better
407 incentives for high-value care.

408 The second point I would like to emphasize is that by
409 giving the Secretary the authority to institute value-based
410 insurance design, we can improve the targeting of cost
411 sharing, making it less likely that cost sharing will have an
412 adverse effect on quality and outcomes.

413 Finally, I would like to emphasize that we would not
414 prohibit Medicare beneficiaries from buying supplemental
415 coverage, even first-dollar coverage, if they so desire. We
416 only think that Medicare beneficiaries should face some of
417 the additional costs that decision imposes on the Medicare
418 program and the taxpayers. I should also emphasize that the
419 supplemental charge we would envision only as part of an
420 overall package. All of these recommendations we see as an
421 integrated package, not isolated recommendations.

422 With that, Mr. Chairman, I welcome your questions.

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423 [The prepared statement of Mr. Hackbarth follows:]

424 ***** INSERT 1 *****

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|
425 Mr. {Pitts.} Thank you, Mr. Hackbarth. The Chair
426 recognizes himself for 5 minutes for questioning.

427 Mr. Hackbarth, many experts have noted that traditional
428 Medicare is an outdated form of health insurance coverage and
429 needs to be modernized. In 1999, AARP's Public Policy
430 Institute published a paper entitled ``The Effects of Merging
431 Part A and B of Medicare.'' They said, ``Medicare's two-part
432 system continues to mirror the structure of private insurance
433 at the time of Medicare's inception in 1965, a structure that
434 often included separate insurance for hospital and physician
435 care.'' Do you agree with the AARP that Medicare's separate
436 hospital and physician benefits closely resemble the type of
437 insurance available to consumers in the 1960s?

438 Mr. {Hackbarth.} Yes.

439 Mr. {Pitts.} Medicare Advantage, a more modern type of
440 coverage signed into law in the late 1990s, is also modeled
441 closely after the types of insurance available to consumers
442 at the time. Do Medicare Advantage plans use separate
443 insurance for hospital and physician care?

444 Mr. {Hackbarth.} No, not to my knowledge, sir.

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445 Mr. {Pitts.} Medicare drug plans are even more modern,
446 having been passed into law by Congress in 2003. Do Medicare
447 drug plans have catastrophic coverage caps?

448 Mr. {Hackbarth.} Yes.

449 Mr. {Pitts.} Is the traditional Medicare benefit the
450 only type of comprehensive coverage in Medicare that does not
451 have a catastrophic coverage cap?

452 Mr. {Hackbarth.} Yes.

453 Mr. {Pitts.} And for the record, is it MedPAC's
454 position that Congress should update traditional Medicare
455 fee-for-service to include a catastrophic coverage cap, among
456 other reforms, because these reforms would benefit seniors.

457 Mr. {Hackbarth.} Yes.

458 Mr. {Pitts.} Thank you. Nearly 50 years have passed,
459 and Medicare's model has become outdated. Seniors deserve a
460 modern product that meets their needs and helps them control
461 cost. I think it is time for Congress to strengthen and save
462 Medicare, making sure that current beneficiaries get what
463 they need and also that future retirees can count on the
464 program being there for them one day.

465 Now, AARP's Public Policy Institute paper also states

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466 that ``A third criticism of two systems of financing for Part
467 A and Part B has hindered management of the original fee-for-
468 service Medicare. Integrating all of Medicare's funding
469 sources into one pool of money would enhance management of
470 health resources and improve accountability for health
471 spending in FFS Medicare.'' Can you tell us your thoughts on
472 what impact this antiquated two-tiered financing system
473 within traditional Medicare has on CMS's ability to manage
474 health spending appropriately, and do you believe it is
475 possible that the antiquated manner in which traditional
476 Medicare fee-for-service is financed might be contributing to
477 the amount of waste, fraud and abuse lost each year?

478 Mr. {Hackbarth.} So you are asking about the financing,
479 separate financing of A and B with payroll tax used to
480 finance Part B and premiums and general revenues for Part B?

481 Mr. {Pitts.} Yes.

482 Mr. {Hackbarth.} We have not specifically looked,
483 Chairman Pitts, at the financing mechanisms and what the
484 implications would be for fraud and abuse. We have focused
485 on the benefit design and payment methods for providers
486 primarily.

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487 Mr. {Pitts.} Now, you state in your testimony one key
488 purpose of insurance is to reduce the financial risk posed by
489 catastrophic medical expenses. To avoid such risk,
490 individuals should be willing to pay a higher premium than
491 the average cost of care they might face. Can you expand on
492 that idea for us?

493 Mr. {Hackbarth.} Well, probably the single most
494 important feature of any insurance program is a limit someone
495 can incur. Now, the medical expense is that most of it is
496 unpredictable. So any given beneficiary in any given year
497 might pay a premium but not use the insurance, may not use
498 the catastrophic cost yet you pay the premium against the
499 risk that it might be your year to have a very serious
500 illness and incur high bills. That is the nature of
501 insurance. A lot of people pay an amount, don't use the full
502 amount, they pay premiums higher than their actual incurred
503 expenses so that when their day comes and unfortunately they
504 suffer a severe illness, the protection is there for them.

505 Mr. {Pitts.} My time is expired. Thank you. The Chair
506 recognizes the ranking member of the subcommittee, Mr.
507 Pallone, for 5 minutes for questions.

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508 Mr. {Pallone.} Thank you, Mr. Chairman.

509 Mr. Hackbarth, I am just following up to some extent on
510 what the chairman just said. While MedPAC included a unified
511 deductible combining the Part A and B deductible into one
512 unified deductible, in your illustrative scenario you did not
513 actually recommend a unified deductible. So why is that?
514 Can you talk about the pros and cons of a unified deductible?

515 Mr. {Hackbarth.} You are correct, Mr. Pallone. We did
516 not specifically recommend a unified deductible. We felt
517 that the precise structure of the cost sharing is a decision
518 that ought to be delegated to the Secretary in keeping with
519 the principles of value-based insurance design. The argument
520 for a combined deductible is that it is simpler and that it
521 is more in keeping with the basic principles of insurance
522 where you want to provide the most protection to patients
523 that have the highest cost. The current structure, as you
524 well know, has a relatively low deductible on Part B and a
525 significantly higher--

526 Mr. {Pallone.} So what is the downside then?

527 Mr. {Hackbarth.} The downside of moving to a combined
528 deductible is the impact on beneficiaries who use only Part B

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529 services in any given year. They would have a higher
530 deductible than the current \$147 that they have in Part B
531 deductible.

532 Mr. {Pallone.} All right. Let me ask about SGR reform.
533 I appreciate the fact that MedPAC continues to lead and
534 support SGR reform and I share the sentiment of the
535 commissions that it is past time to take action. I also
536 appreciate the recognition that we need to move delivery
537 systems and payment systems reform to more value-based
538 systems that were included in the ACA like the medical homes
539 and accountable care organizations. But with regard to SGR
540 reform, is my understanding correct that MedPAC is not
541 recommending that costs be shifted to beneficiaries?

542 Mr. {Hackbarth.} Well, we have recommended in benefit
543 design, as I said in my opening comment, that the average
544 liability for beneficiaries not be increased.

545 Mr. {Pallone.} Okay. So just to clarify further,
546 MedPAC has not recommended that an SGR fix be offset within
547 Medicare. Is that accurate?

548 Mr. {Hackbarth.} We did not recommend that. We believe
549 that is Congress's decision to make. What we have tried to

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550 do is offer options for offsetting the cost within Medicare
551 if Congress elects to fully offset SGR within Medicare.

552 Mr. {Pallone.} But you are not recommending that be
553 offset within Medicare?

554 Mr. {Hackbarth.} We have not.

555 Mr. {Pallone.} Now, I am concerned that some people are
556 eyeing this idea of Medicare benefit redesign as a way to
557 simply get budgetary savings by shifting more costs onto the
558 backs of beneficiaries. However, in looking at your redesign
559 recommendations, I notice that you recommend beneficiary
560 liability remains neutral, that overall beneficiary cost-
561 sharing levels stay the same in aggregate. So even though
562 some beneficiaries will see their costs go up and some will
563 see their costs will go down, the overall out-of-pocket costs
564 for the average beneficiary will stay the same. So am I
565 reading that correctly, that MedPAC doesn't envision or
566 propose any savings from benefit redesign itself?

567 Mr. {Hackbarth.} From the redesign itself, no, sir.

568 Mr. {Pallone.} So in your proposal, isn't it true that
569 the savings come from the tax on first-dollar supplemental
570 coverage?

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571 Mr. {Hackbarth.} That is correct.

572 Mr. {Pallone.} And was keeping beneficiary liability
573 neutral an important principle for the commission? Did you
574 want to comment on that?

575 Mr. {Hackbarth.} Yes, it is a very important principle
576 from our perspective. As I said in my opening comment, we
577 don't think the current benefit package is too rich. If
578 anything, it is too lean. Our principal concerns about it
579 are its inappropriate structure. It is not well designed for
580 the needs of the Medicare population, and we think it should
581 be restructured.

582 Mr. {Pallone.} Can you share with us why not cost
583 shifting to beneficiaries was felt to be so important? Do
584 you want to comment on that as well? I know you have to some
585 extent.

586 Mr. {Hackbarth.} Well, as I say, we think for the
587 population served, which is an older obviously somewhat
588 higher-risk population, this is not a rich benefit package
589 compared to what employment-based coverage offers, for
590 example, and so rather than try to achieve savings by cutting
591 benefits, we thought it was better to redesign them. Now, it

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592 is possible that if we have a simpler design and one that
593 includes catastrophic coverage that some beneficiaries will
594 choose to forego supplemental insurance over time, and if
595 that happens, we would expect that that might result in lower
596 utilization because there would be most cost sharing at the
597 point of service but it would be the beneficiary's choice to
598 do that.

599 Mr. {Pallone.} All right. Thank you so much. Thank
600 you, Mr. Chairman.

601 Mr. {Pitts.} The Chair thanks the gentleman and now
602 recognizes the vice chairman of the subcommittee, Dr.
603 Burgess, for 5 minutes for questions.

604 Dr. {Burgess.} Thank you, Mr. Chairman.

605 Mr. Hackbarth, let me just ask you, in a Medicare
606 Advantage system, would a patient buy supplemental insurance
607 for Medicare Advantage?

608 Mr. {Hackbarth.} Typically, they would not. Medicare
609 advantage is offering a different set of tradeoffs, so
610 typically patients have lower cost sharing at the point of
611 service in exchange for agreeing to perhaps network
612 limitations that they are steered to particular providers by

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613 the insurer or their benefits are subject to utilization
614 management, you know, prior authorization or other management
615 controls, so that is the tradeoff: lower cost sharing, more
616 management.

617 Dr. {Burgess.} I guess I am having a hard time
618 understanding. It seems like if someone buys a supplemental
619 insurance policy as they enter into Medicare, they are doing
620 the responsible thing by putting some of their own dollars
621 into their future health care by covering against what would
622 be excessive out-of-pocket costs if they get sick. So they
623 are--it looks to me from a physician's standpoint, they are
624 doing the prudent thing. Now, I honestly can't tell you that
625 I ever got a reimbursement check from a Medigap policy, so I
626 don't know. Maybe those dollars never go where they are
627 supposed to. But it looks like the patient is doing the
628 prudent thing with doing that, but you seem to articulate a
629 different opinion.

630 Mr. {Hackbarth.} Well, our view is not for or against
631 the purchase of supplemental insurance. We believe that
632 beneficiaries should have the option of buying supplemental
633 insurance, even first-dollar supplemental coverage, if that

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634 is what they wish. We do think that they ought to see more
635 of the costs that result from that private decision. The
636 premium that they pay for supplemental insurance reflects
637 only a fraction of the additional costs that result from that
638 decision.

639 Dr. {Burgess.} But ultimately that is why someone buys
640 insurance, correct, so they are not hit with the entire cost
641 of whatever the event might be that they are insured against.

642 Mr. {Hackbarth.} Yes, but even insuring against this
643 event, they are underpaying for that cost. The right price
644 for insurance should reflect the full cost of the purchasing
645 decision. In the case of supplemental insurance, it does
646 not. It reflects only a fraction of the cost.

647 Dr. {Burgess.} Let me interrupt you because my time is
648 going to run. I don't want to say whose fault is that, but
649 why penalize the poor person who is trying to do the right
650 thing and buying supplemental coverage with their own hard-
651 earned dollars? It doesn't make sense to me to penalize or
652 tax that person additionally if you want them to be bringing
653 some of their own dollars to the system to keep the system
654 solvent.

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655 Mr. {Hackbarth.} But we only want for beneficiaries to
656 see more of the cost of the decision that they make.

657 Dr. {Burgess.} I don't disagree with you. I mean, I
658 think we have anesthetized people as to what health care
659 really costs, and that is the argument for the entire health
660 savings account third-party payment mechanism that is
661 ubiquitous in health care, and perhaps we can talk about that
662 at another time.

663 When President Obama was doing his charm offensive up
664 here a couple of weeks ago and met with House Republicans
665 down in the basement, I have got to tell you, several years
666 ago in one of the SGR fixes that I have introduced since
667 coming to Congress, and there have been several, but one of
668 them actually did away with Part A and Part B and melded them
669 together. I got a lot of pushback when I introduced that.
670 So I was surprised to hear the president say sort of one of
671 the throwaway lines in answer to a question was, we could
672 combine Part B and Part B. I guess as I further understand
673 it, that was combining the deductibles. But is that a
674 rational approach to dealing with some of these difficulties?

675 Mr. {Hackbarth.} Well, again, we in our recommendation

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676 did not specifically recommend a combined deductible. We did
677 recommend catastrophic covers both A and B. On the issue of
678 the combined deductible, we think that actually that is a
679 decision that ought to be part of an overall redesign of the
680 cost sharing in keeping with the principles of value-based
681 insurance design.

682 Dr. {Burgess.} We do of course end up with some people
683 who don't participate in Part B. They have their Part A
684 coverage because of the payroll deduction that they have
685 contributed throughout their working lives. So it is not a
686 completely universal population.

687 Let me just ask you another question. Cardiologists in
688 this country 4 to 5 years underwent a practice upheaval, and
689 largely because of the administrative pricing brought to them
690 by Medicare. In other words, to do an echo or a treadmill
691 test in the office suddenly was undervalued and it was
692 overvalued, in my opinion, to do that in the hospital, and as
693 a consequence you have seen cardiologists leave their
694 individual practices and be hired by hospitals and insurance
695 companies so that the private practice, solo practice of
696 cardiology has gone away and yet the technology is changing

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697 such that, I don't know, NBC has a special on the other night
698 where Dr. Snyderman interviewed Dr. Topol out of San Diego,
699 and with a smartphone and a couple of little adapters, he was
700 able to do an EKG, an echocardiogram and a continuous
701 transcutaneous glucose monitoring. He was providing a lot of
702 care at a very low cost in an office setting but we have kind
703 of actually priced him out of business, have we not, with our
704 administrative pricing in Medicare?

705 Mr. {Hackbarth.} Well, as you know, Dr. Burgess, one of
706 the issues that we are working on currently is synchronizing
707 the payment systems between the hospital outpatient
708 departments and physician offices. So historically, there
709 have been dramatically different prices paid for the same
710 service based on the location, physician office versus
711 outpatient department. That is the problem, and that is
712 skewing incentives, and we think contributing to the
713 migration of physician practices including cardiology
714 practices from outpatient privately owned offices into
715 hospital outpatient departments.

716 Dr. {Burgess.} But I think Medicare was the cause of
717 that rather than the effect, your reimbursement.

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718 I realize my time is up, Mr. Chairman. I will yield
719 back.

720 Mr. {Pitts.} The Chair thanks the gentleman and now
721 recognizes the ranking member emeritus, Mr. Dingell, for 5
722 minutes for questions.

723 Mr. {Dingell.} Mr. Chairman, thank you for holding this
724 hearing and thank you for the recognition, and to our
725 witness, thank you. You have given us very excellent
726 testimony this morning.

727 As you will recall, it is my practice to ask for yes or
728 no answers. I invite you, if you can, to give us
729 supplemental information as you might deem to be appropriate.

730 Mr. {Hackbarth.} I will try, Mr. Dingell.

731 Mr. {Dingell.} We very much appreciate that.

732 My old friend Hubert Humphrey once said the moral test
733 of a government is how the government treats those who are in
734 the dawn in life, in the twilight of life and in the shadows
735 of life. Medicare helps our country meet that moral test by
736 ensuring that our sick and elderly have access to care in the
737 time of need. My old dad was one of the architects of
738 Medicare, and it has endured as one of the great and

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739 significant pieces of legislation.

740 Now, Mr. Hackbarth, I want to again express my
741 appreciate for your fine testimony this morning. You note in
742 your testimony that the cost-sharing structure of fee-for-
743 service benefit has remained unchanged since 1965. Is that
744 correct?

745 Mr. {Hackbarth.} Literally, no, it has not. There have
746 been some changes.

747 Mr. {Dingell.} Have there been any really significant
748 changes?

749 Mr. {Hackbarth.} No.

750 Mr. {Dingell.} All right. Would you submit that for
751 the record?

752 The current fee-for-service benefit has significant
753 cost-sharing requirements for beneficiaries. Is that
754 correct?

755 Mr. {Hackbarth.} Yes.

756 Mr. {Dingell.} Almost 90 percent of fee-for-service
757 beneficiaries have supplemental coverage. Is that correct?

758 Mr. {Hackbarth.} Yes.

759 Mr. {Dingell.} Do you agree that the beneficiaries may

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760 choose to have supplemental coverage due to cost-sharing
761 requirements in the current fee-for-service system?

762 Mr. {Hackbarth.} Yes.

763 Mr. {Dingell.} MedPAC has proposed an additional charge
764 on supplemental coverage on Medigap and employer-sponsored
765 retiree plans. Is that correct?

766 Mr. {Hackbarth.} Yes.

767 Mr. {Dingell.} And you have proposed this charge
768 because the commission believes that supplemental coverage
769 leads to increased utilization and spending. Is that
770 correct?

771 Mr. {Hackbarth.} Yes.

772 Mr. {Dingell.} And it would also be fair to say, as you
773 have observed earlier, that it is necessary for us to recoup
774 some of the additional burdens that that imposes on the
775 Medicare trust fund. Is that right?

776 Mr. {Hackbarth.} Yes.

777 Mr. {Dingell.} Do you think that an appropriate charge
778 would be--what do you think would be an appropriate charge on
779 supplemental coverage?

780 Mr. {Hackbarth.} Can I--

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781 Mr. {Dingell.} That is not a yes or no answer.

782 Mr. {Hackbarth.} Good. We modeled 20 percent, a 20
783 percent charge, but we did not recommend a specific number.

784 Mr. {Dingell.} I would appreciate if you would make
785 some additional submissions to us on that point because it is
786 a very important question.

787 Who would be required to pay this charge? Now, we have
788 some potentials here. Would it be individual policies?

789 Mr. {Hackbarth.} We would impose it on the insurance
790 company, and then it could be passed through in the premium,
791 depending on how the market sorts it out.

792 Mr. {Dingell.} Would it be on employer-sponsored
793 retiree plans?

794 Mr. {Hackbarth.} Yes.

795 Mr. {Dingell.} And would it be applied only to new
796 beneficiaries?

797 Mr. {Hackbarth.} No.

798 Mr. {Dingell.} Would it be applied to everybody?

799 Mr. {Hackbarth.} Yes.

800 Mr. {Dingell.} I know the Administration seems to be
801 saying that these charges will be applied only to new

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802 beneficiaries after 2017.

803 Mr. {Hackbarth.} Yes.

804 Mr. {Dingell.} Do you agree that the supplemental
805 charge would cause Medicare beneficiaries to face additional
806 cost sharing? Now, you have some comments on that. Do you
807 want to amplify on that?

808 Mr. {Hackbarth.} Could you just repeat it again?

809 Mr. {Dingell.} Okay. Do you agree that the
810 supplemental charge would cause Medicare beneficiaries to
811 face additional cost sharing?

812 Mr. {Hackbarth.} Well, certainly the supplemental
813 charge itself would be an additional cost. How beneficiaries
814 would respond to that is difficult to predict. What we think
815 would happen is, the current beneficiaries may not change
816 their choice of policies as significantly as new
817 beneficiaries coming into the program over time.

818 Mr. {Dingell.} Now, you have indicated that you don't
819 intend to increase the burden on the population of
820 beneficiaries generally. Am I correct in that?

821 Mr. {Hackbarth.} In our benefit redesign?

822 Mr. {Dingell.} Yes.

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823 Mr. {Hackbarth.} No. We went to hold that constant.

824 Mr. {Dingell.} Now, do you agree that the supplemental
825 charge could cause some beneficiaries to drop or reduce their
826 supplemental coverage due to the additional charge?

827 Mr. {Hackbarth.} We that it may cause some
828 beneficiaries to change their choices. As you well know,
829 there are a wide range of supplemental plans. Some have
830 front-end cost sharing; some do not. So there might be a
831 move from first-dollar supplemental coverage to policies that
832 have some cost sharing at the point of service.

833 Mr. {Dingell.} Now, I have to think that a charge on
834 supplemental coverage could result in Medicare beneficiaries
835 not seeking out the services and care they need or delaying
836 treatment or care until it is too late. I think that is a
837 potential risk but first, is it a risk, and second, what do
838 we do about it?

839 Mr. {Hackbarth.} It is a risk, and this is why we think
840 it is very important to give the Secretary to the authority
841 to adjust cost sharing based on the principles of value-based
842 insurance design. In other words, reduce cost sharing for
843 services of proven high value to patients and perhaps

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844 increase cost sharing for low-value services.

845 Mr. {Dingell.} So you are suggesting the Secretary
846 should have authority to adjust those charges but that should
847 be subject again to requirements in law that would say he
848 can't necessarily change the overall structure to create a
849 disadvantage to the population. Is that right?

850 Mr. {Hackbarth.} Exactly.

851 Mr. {Dingell.} Mr. Chairman, I have gone over time.

852 Mr. {Pitts.} The Chair thanks the gentleman and now
853 recognizes the gentleman from Virginia, Mr. Griffith, 5
854 minutes for questions.

855 Mr. {Griffith.} Thank you, Mr. Chairman.

856 I was intrigued with your testimony in regard to
857 secretarial authority to alter or eliminate cost sharing
858 based on the evidence of the value of services, and I was
859 wondering if you could expand on that because one of my
860 concerns would be, I understand if something has a high
861 benefit, lowering that cost pay, but you could theoretically
862 raise the copay so high that people couldn't afford it, even
863 if they really wanted to do that, and I am concerned that for
864 a particular patient and a particular doctor, they may make a

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865 decision that perhaps universally might not have great
866 benefit but could to that patient. I was wondering if you
867 could expand on that. My thought was, maybe put caps on the
868 high end.

869 Mr. {Hackbarth.} So as you know, a number of private
870 insurers and employers have been moving towards the idea of
871 value-based insurance design. Typically, the focus has been
872 on reducing patient copays for services of high proven value.
873 An example would be having low copays for services provided
874 to diabetics or patients with multiple chronic illnesses to
875 make sure that they get the care they need to prevent
876 worsening of their health and potentially higher bills as a
877 result of that. There has been less done in terms of
878 increasing copays for low-value services, probably for the
879 obvious reason that there is more controversial than
880 reductions are. So I would anticipate that at least
881 initially most of what the Secretary might do with this
882 authority is lower copays. That said, there are services
883 that sometimes can be quite expensive but are of low value to
884 patients, and rather than prohibit access to those services
885 and say oh, you are a Medicare beneficiary, you can't have

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886 that service at all, the idea would be to say okay, you can
887 have it but you are going to pay a bit more of the cost of
888 that service if it is a proven low-value service.

889 Mr. {Griffith.} And I don't come from a medical
890 background. Can you give me an example of one of those that
891 across the country would have low benefit and might need to
892 have the fee raised?

893 Mr. {Hackbarth.} Since I am not a physician either, I
894 would be reluctant to do that. What I would say is that, you
895 know, this should be done thoughtfully and will be done as
896 part of a notice and comment rulemaking process so the
897 Secretary would have to publish the evidence to support this
898 low-value assessment, and all relevant parties would have the
899 opportunity to contest that evidence and respond to it, and I
900 think that is the way it ought to be decided by experts, not
901 by people like me.

902 Mr. {Griffith.} As a representative of the public, and
903 while I generally think experts do a pretty good job,
904 sometimes I have big disagreements with them and I would just
905 have to say that while I kind of like the idea, Mr. Chairman,
906 I would want to see--if we were to authorize the Secretary to

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907 do that, I would want to see some kind of a cap on the top of
908 the--as a top number so that you wouldn't be in a position
909 where suddenly a procedure is completely voided because the
910 cost is just so horrendous that nobody can justify it except
911 for the extremely rich. So I do appreciate that.

912 With that, Mr. Chairman, I will yield back my time.

913 Mr. {Pitts.} The Chair thanks the gentleman and now
914 recognizes the gentleman from Utah, Mr. Matheson, 5 minutes
915 for questions.

916 Mr. {Matheson.} Thank you, Mr. Chairman, and thank you,
917 Mr. Hackbarth, for being here today.

918 It seems to me that one of the outcomes of your
919 suggested change in this benefit design has something to do
920 with overutilization and trying to address that issue in
921 terms of having the individual patient have a little more of
922 a consumer orientation. Is that a fair assumption?

923 Mr. {Hackbarth.} That is part of it, Mr. Matheson, but
924 the most important part from our perspective is to improve
925 the benefit package for beneficiaries including catastrophic
926 coverage.

927 Mr. {Matheson.} I wanted to talk a little bit about a

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928 particular component of overutilization. I may be getting a
929 little off the specific benefit design topic of this hearing,
930 but I know in your MedPAC March report you identified some
931 specific geographic areas where there is a strong reason to
932 believe that certain inappropriate billing practices are at
933 play in the home health care industry, and I have seen some
934 data that is pretty phenomenal in my mind. I compare my
935 State to Miami-Dade County. I got 190,000 Medicare
936 beneficiaries in Utah. There are about that many in Miami-
937 Dade County. However, there is 700 home health care
938 providers in Miami-Dade County and about 100 in Utah. Home
939 health services in Utah cost Medicare a lot less than the
940 services performed in Miami-Dade. The average cost per
941 enrollee in Utah is \$560. The average cost in Miami-Dade
942 County per enrollee is over six times that amount of \$3,500.
943 It strikes me that the vast majority of providers in the home
944 health care industry in Utah are doing the right thing, and
945 it strikes something is going on in Miami-Dade County that
946 doesn't pass the smell test, and it seems to me that it is an
947 important issue for us to look at in how we try to seek out
948 these pockets of geographic areas where there is this huge

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949 overutilization going on and instead of doing a policy that
950 may affect all providers including those that are doing the
951 right thing that we target those who aren't. So in the
952 instance of home health care, I was wondering, would it be
953 better for Medicare in terms of saving money and decreasing
954 overutilization to scrutinize the issue of new provider
955 numbers or to look at reasonable limits on episodes of care
956 in these high utilization areas like Miami-Dade County?

957 Mr. {Hackbarth.} There are two types of problems in
958 home health care as we see it, but before I focus on the
959 problems, let me emphasize that we think that good home
960 health care is an essential part of good quality care for
961 Medicare beneficiaries.

962 Mr. {Matheson.} And I agree.

963 Mr. {Hackbarth.} So in no sense are we against home
964 health care, but there is, as you say, evidence that in some
965 parts of the country we have extraordinary levels of use and
966 extraordinary number of home health agencies and we think
967 indications of fraud and abuse, and we have made
968 recommendations for targeted efforts to deal with those
969 problems including limits on the number of new agencies in

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970 those problem areas, so we think that is an important thing
971 to do.

972 Having said that, though, across the country, we
973 believe, even in the low-use States we are paying too much
974 for each episode of home health care. So even where there
975 isn't that fraud and abuse, we believe the rates are too high
976 relative to the costs incurred.

977 Mr. {Matheson.} In terms of this situation where you
978 have got some certain geographic locations where there
979 appears to be extremely high overutilization compared to a
980 peer comparison elsewhere, is it reasonable to assume that
981 this situation is occurring in other aspects of Medicare
982 services in this country outside of home health care?

983 Mr. {Hackbarth.} Well, quite possibly, yes. Another
984 area where we see extreme variation is durable medical
985 equipment. So post acute care in general which includes home
986 health care and DME account for a significant portion of the
987 geographic variation that is the focus of so much attention
988 in Medicare.

989 Mr. {Matheson.} We feel like in our State, we practice
990 medicine in a way that if the rest of the country did it, we

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991 would be saving a lot of money with outcomes just as good,
992 and so I think this is something, Mr. Chairman, I know it is
993 a little outside of the benefit structure of this hearing
994 today but this issue of disparate discrepancies in
995 utilization across different geographic areas is something I
996 think is worthwhile for us all to take a look at and provide
997 some real opportunity for some savings. With that, I will
998 yield back.

999 Mr. {Pitts.} The Chair thanks the gentleman and now
1000 recognizes the gentleman from Kentucky, Mr. Guthrie, 5
1001 minutes for questions.

1002 Mr. {Guthrie.} Thank you, Mr. Chairman, and I would
1003 like to follow up a little bit on what my friend from Utah
1004 was talking about, because you have talked about and you
1005 mentioned again the high margins in home health, and I know
1006 home health, in my understanding, has been cut, what, 21
1007 percent since 2010 and for publicly traded home health--that
1008 is the information I was able to get--before tax margins in
1009 2009 were 13.4 percent, in 2012, 3.9 percent. I think there
1010 is four publicly traded. And after tax margin in 2012 was
1011 2.5 percent. So it seems like if you had more in Miami, you

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1012 would get better competition, so it is kind of
1013 counterintuitive how that works.

1014 And I guess my question is, you have a report that had
1015 the margins. What was your methodology in that report?

1016 Mr. {Hackbarth.} We used Medicare cost reports, so in
1017 contrast to the publicly traded companies, what we are
1018 looking at is Medicare-specific profit margins whereas for a
1019 publicly traded company, we would be getting a combination of
1020 Medicare margins and margins on private insurance as well.

1021 Mr. {Guthrie.} Okay.

1022 Mr. {Hackbarth.} So it is an apples-to-oranges
1023 comparison.

1024 Mr. {Guthrie.} Well, thanks for that. On the
1025 supplementals, so you were saying the number you have
1026 suggested--I know you didn't recommend it--is 20 percent, or
1027 looked at 20 percent should be actually added to the--you
1028 said charge to the insurer but the premium should be 20
1029 percent higher to reflect the true cost to the taxpayer for
1030 buying supplemental--

1031 Mr. {Hackbarth.} Yes, so the example that we modeled
1032 was a 20 percent charge that would be imposed on the

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1033 insurance. How that would affect the premiums would depend
1034 on, you know, market competition and different markets. In
1035 some cases, it might be all passed on. In other words, it
1036 might not be.

1037 Mr. {Guthrie.} So the additional cost that you are
1038 trying to capture is what the supplemental policy does in
1039 terms of utilization?

1040 Mr. {Hackbarth.} Increased utilization, so our analysis
1041 shows that beneficiaries that have supplemental coverage use
1042 about one-third more services after adjusting for differences
1043 in age and risk, etc.

1044 Mr. {Guthrie.} Because the more likely you are to use
1045 the system, the more you--so the sicker you are, the more
1046 likely you are to buy a supplemental policy?

1047 Mr. {Hackbarth.} But in our analysis, we adjust for
1048 risk.

1049 Mr. {Guthrie.} Well, thanks. I yield back my time.

1050 Mr. {Pitts.} The Chair thanks the gentleman and now
1051 recognizes the gentleman from Texas, Mr. Green, for 5
1052 minutes.

1053 Mr. {Green.} Thank you, Mr. Chairman.

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1054 Mr. Hackbarth, thank you for appearing today, and again,
1055 thank you for a lot of the information we worked on for many
1056 years. MedPAC's proposal for benefit redesign is careful to
1057 point out that aggregate beneficiary cost sharing would be
1058 kept the same. You point out in your testimony that the
1059 reason for this is the commissioners' judgment that
1060 traditional Medicare's benefit structure is not too rich,
1061 especially for the population covered. One of your goals is
1062 to protect the beneficiaries against high out-of-pocket
1063 spending while not reducing the actuarial value of the
1064 benefit package. Can you explain what you mean by the
1065 benefit package not being too rich?

1066 Mr. {Hackbarth.} Right. So a way to judge the richness
1067 of a benefit package is, what percentage of a patient's costs
1068 are paid through insurance as opposed to out of pocket.
1069 Using that as the standard, we don't think that the
1070 percentage paid by Medicare of total beneficiary costs is too
1071 high. In fact, if anything, it may be too low. So we
1072 accepted as a starting point that we ought not be cutting the
1073 amount paid by Medicare that would put too much of a burden
1074 on beneficiaries. We felt like there were a lot of things we

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1075 could do to make the package better including providing
1076 catastrophic coverage and making it simpler. We thought that
1077 those changes in turn might cause some beneficiaries to say,
1078 you know, I don't need to pay \$175 or \$200 a month for
1079 supplemental insurance, which is a big burden on many
1080 beneficiaries as well.

1081 Mr. {Green.} Frankly, in our area, \$175 or \$200 a month
1082 is pretty small. I have seen some quotes for that.

1083 Now, switching gears. A lot of attention has been given
1084 to supplemental insurance plans like you just mentioned in
1085 Medicare, particularly those provided by employers or Medigap
1086 plans purchased by individuals. There is a lot of concern
1087 about Medicare patients not having enough skin the game, so
1088 to speak, because their supplemental policies often pick up
1089 deductibles, copays and coinsurance. As I understand your
1090 proposal, charging or paying a premium for this first-dollar
1091 supplemental insurance is intended to offset the cost of some
1092 of the other benefit design changes?

1093 Mr. {Hackbarth.} Well, the overall package that we
1094 modeled including the catastrophic coverage and the new
1095 structure of copays would have resulted in a modest increase

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1096 in Medicare expenditures, about 1 percent, and so in our
1097 package we combined that modest increase with this 20 percent
1098 charge on supplemental insurance and the net result of those
1099 two things would be a modest reduction in total Medicare
1100 expenditures of about one-half of 1 percent.

1101 Mr. {Green.} I understand that correctly. Is it true
1102 that cost sharing reduces both necessary and unnecessary
1103 care?

1104 Mr. {Hackbarth.} Yes. That is what the evidence shows,
1105 and that is why we think that giving the Secretary the
1106 authority to do smarter cost sharing, not just across the
1107 board but targeted based on value is so important.

1108 Mr. {Green.} And I understand that we want patients
1109 more active in their decisions on their care but that may
1110 work for some of us that are younger elderly patients but a
1111 lot of our older patients how are sicker, they just may take
1112 a more passive role in their care and their decision making,
1113 and Mr. Chairman, I remember I was a State legislator in the
1114 1980s and we had a Senator from Texas, Lloyd Bentsen, who
1115 worked on trying to do catastrophic and reform Medicare, and
1116 somehow the seniors got Congress's attention, and I remember

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1117 talking to Senator Bentsen at that time and he said we just
1118 went too far for what our seniors would accept, and it was,
1119 you know, a revolution by those under Medicare almost in the
1120 late 1980s.

1121 Mr. {Hackbarth.} In fact, I worked in what was then
1122 HCFA, the Health Care Financing Administration, during that
1123 period, so I remember it well.

1124 Mr. {Green.} And I understand, Mr. Chairman, there are
1125 some good parts of this but we need to look at it because a
1126 lot of seniors would like not to have to have that high
1127 monthly premium for their Medigap coverage, if we could
1128 somehow equal it out.

1129 Mr. {Hackbarth.} And unfortunately, I think the current
1130 structure without catastrophic coverage almost compels
1131 seniors to pay that high monthly premium for supplemental
1132 insurance because the Medicare package does not offer them
1133 the most basic feature of a good insurance plan, an out-of-
1134 pocket limit.

1135 Mr. {Green.} Thank you, Mr. Chairman.

1136 Mr. {Pitts.} The Chair thanks the gentleman and now
1137 recognizes the gentlelady from North Carolina, Ms. Ellmers, 5

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1138 minutes for questions.

1139 Mrs. {Ellmers.} Thank you, Mr. Chairman.

1140 Mr. Hackbarth, I have a document here which is basically
1141 a list of bipartisan quotes from both conservative and
1142 progressive authors relevant to the proposals, many of which
1143 you are proposing today, and I will just say that drawing
1144 from it, President Obama's National Commission on Fiscal
1145 Responsibility and Reform released in 2010 quoted--this is a
1146 quote taken from that bit of information: ``Currently,
1147 Medicare beneficiaries must navigate a hodgepodge of
1148 premiums, deductibles and copays that offer neither spending
1149 predictability nor protection from catastrophic financial
1150 risk. The ability of Medicare cost sharing to control costs
1151 either under current law or as proposed above is limited. Do
1152 you believe--and I think you can probably just give a yes or
1153 no answer to this. Do you believe that MedPAC's reforms ad
1154 they encourage more predictable out-of-pocket costs and limit
1155 on catastrophic costs may allow seniors to better plan for
1156 balance in their future health care and financial needs?

1157 Mr. {Hackbarth.} Yes.

1158 Mrs. {Ellmers.} Thank you. In 1995, Henry Aaron of the

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1159 Brookings Institute and Robert Reischauer of the Urban
1160 Institute had this to say about combining Medicare Part A and
1161 Part B: ``Whatever rationale may once have existed for the
1162 distinction between services and Part A and Part B medical
1163 technology, the development of new reforms and service
1164 delivery and new patient structures have rendered it
1165 obsolete.'' I raise this point because we think it is
1166 important as part of the conversation today that we all
1167 understand that Medicare traditional benefits are obviously
1168 outdated and cause unnecessary harm for our seniors as a
1169 result. There again, in your opinion, yes or no, do you
1170 believe the concept of combining Part A and Part B is a good
1171 Medicare idea?

1172 Mr. {Hackbarth.} Yes. As I said earlier, our
1173 recommendation is for a combined A and B catastrophic limit.
1174 We have not specifically recommended an A and B combined
1175 part.

1176 Mrs. {Elmers.} And do you believe that the concept of
1177 this can be characterized as a Republican idea?

1178 Mr. {Hackbarth.} Well, this package that I have
1179 described today was unanimously recommended by the members of

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1180 MedPAC, 17 members of various political persuasion.

1181 Mrs. {Ellmers.} So basically you would have to say no
1182 then?

1183 Mr. {Hackbarth.} We are a nonpartisan agency and we
1184 really try to live up to that billing.

1185 Mrs. {Ellmers.} To be bipartisan. Okay. The AARP's
1186 Public Policy Institute had this to say about the traditional
1187 Medicare benefit designed in 1999: ``Medicare, widely
1188 considered to have been successful in improving access to
1189 care and lessening the financial burdens of health care for
1190 older Americans, is also viewed as a program in need of a
1191 more updated management structure. The two-part system that
1192 drives many of its payments and revenue policies almost
1193 certainly would not be adopted if the program were being
1194 designed today. The current design reflects some factors
1195 that while relevant when Medicare was initiated in 1965 are
1196 not now pertinent.'' In your opinion, do you believe that
1197 the current design of Medicare traditional benefits reflects
1198 some factors that may have been more relevant in 1965 as
1199 opposed to now, 2013?

1200 Mr. {Hackbarth.} Yes.

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1201 Mrs. {Ellmers.} Wonderful. I have a couple minutes.
1202 We are going to be taking part--Congresswoman Marsha
1203 Blackburn and I are going to be taking part in a committee
1204 idea lab, basically just bouncing some ideas and thoughts,
1205 after this hearing. Some of the proposals outlined by MedPAC
1206 will be included in our proposal and some of the questions we
1207 are going to be taking. I look forward to working with this
1208 committee over the next months to explore these ideas and
1209 push forward meaningful Medicare reforms that serve the best
1210 interest of Medicare seniors, and at this time I would like
1211 to ask unanimous consent to insert into the record this piece
1212 of information that we have here, this review of bipartisan
1213 support.

1214 Mr. {Pitts.} Without objection, so ordered.

1215 [The information follows:]

1216 ***** COMMITTEE INSERT *****

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1217 Mrs. {Ellmers.} Thank you, Mr. Chairman, and I yield
1218 back the remainder of my time.

1219 Mr. {Pitts.} The Chair thanks the gentlelady and now
1220 recognize the gentlelady from Virgin Islands, Dr.
1221 Christensen, for 5 minutes for questions.

1222 Dr. {Christensen.} Thank you, Mr. Chairman, and thank
1223 you, Dr. Hackbarth, for coming back to the committee. I
1224 appreciate MedPAC's recognition of the need for added
1225 protections, particularly with regard to the out-of-pocket
1226 spending caps in your benefit design proposal, and I think I
1227 understand but don't necessarily agree with some of the ideas
1228 behind the proposed reform of supplemental or Medigap
1229 coverage, but I am very concerned with the level of support
1230 and protections for low-income seniors and that analyses done
1231 on the impact of seniors as a group may not adequate capture
1232 the impact on those that are most vulnerable. Every study
1233 that I have reviewed looking at the impact of the cost
1234 sharing on patients and patient behaviors concludes the same
1235 thing, that patients use less services but do not
1236 differentiate between necessary and unnecessary and that

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1237 those that are poorer and sicker are the most cost-sensitive
1238 and would be the ones that would reduce the use of services
1239 the most.

1240 So as you know, the Medicare beneficiaries are poorer
1241 and sicker than the population at large. Twenty-three
1242 percent have a cognitive or mental impairment. Forty percent
1243 have three or more chronic medical problems. About half of
1244 the beneficiaries have annual incomes below 200 percent of
1245 poverty level, and one-quarter have incomes less than \$14,000
1246 per year. So these beneficiaries are very much the patient
1247 population that is at greatest risk for reducing the use of
1248 necessary medical services or deferring important care that
1249 results in a preventable hospitalization, and I know you have
1250 thought about these issues because your proposal builds in
1251 protections for those currently covered by Medicaid. What
1252 about the other low-income seniors and the ones, the 40
1253 percent with multiple chronic diseases for whom we don't
1254 really want to create additional barriers to care.

1255 Mr. {Hackbarth.} So Dr. Christensen, I agree basically
1256 with your summary of what the evidence shows about cost
1257 sharing, and so I want to emphasize again, our goal is not to

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1258 increase the average level of cost sharing but redesign the
1259 benefit to make it better for Medicare patients and perhaps
1260 reduce the need for them to buy supplemental coverage. We
1261 think that using value-based insurance design is very
1262 important to get at some of the issues you have identified.
1263 We don't want to increase cost sharing on really high-value
1264 services, for example, for chronically ill patients. In
1265 fact, we may want to reduce cost sharing on those.

1266 With regard to the impact on low-income people, we think
1267 that there are targeted approaches to dealing with that issue
1268 that are better than what we now have. Right now, what we
1269 have is a system whereby in effect the taxpayers are
1270 providing an implicit subsidy for the purchase of
1271 supplemental coverage because the taxpayers pick up most of
1272 the bill for the added cost. That subsidy goes to all
1273 beneficiaries rich and poor alike. If the particular concern
1274 is low-income beneficiaries as well as might be, a more
1275 targeted way to deal with that issue would be to expand
1276 eligibility for the Medicare savings programs. So right now
1277 Medicare beneficiaries that have incomes less than 100
1278 percent of poverty qualify to get their Part B premiums and

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1279 cost sharing paid under Medicaid, but above that level, there
1280 is no contribution for offsetting cost sharing. Up to 135
1281 percent of poverty, there are subsidies for the Part B
1282 premium but you still have to pay the cost sharing. So if
1283 Congress is concerned about low-income people and the impact
1284 of this on low-income people, a much more targeted approach
1285 would be to change eligibility for the Medicare savings
1286 programs, and I would note that the low-income subsidy under
1287 Part D has higher income thresholds for eligibility than we
1288 have in the Medicare savings programs for Part A and B, so
1289 there is already a precedent, if you will, for higher levels
1290 of eligibility.

1291 Dr. {Christensen.} Thank you for that. That gives us
1292 some idea of where to go.

1293 You talk a lot about giving the Secretary flexibility to
1294 set copays for high value versus low value, and I have been
1295 following the Patient-Centered Outcome Research we created in
1296 the Affordable Care Act, and I am wondering, do you see that
1297 as being helpful, their work as being helpful to identify
1298 high volume, low value in that process?

1299 Mr. {Hackbarth.} Yes. A number of years ago, before

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1300 the Patient-Centered Outcome Research Institute was created,
1301 we recommended to Congress that such an organization be
1302 created and that the federal government support the
1303 development of better information for physicians and patients
1304 about what works, and so to the extent that PCORI can
1305 increase the knowledge base that we have, that is information
1306 that could be used in value-based insurance design.

1307 Dr. {Christensen.} Thank you. Thank you, Mr. Chairman.
1308 I yield back.

1309 Mr. {Pitts.} The Chair thanks the gentlelady and
1310 recognizes the gentlelady from Tennessee, Ms. Blackburn, 5
1311 minutes for questions.

1312 Mrs. {Blackburn.} Thank you so much. We appreciate
1313 that you are taking the time to be here, and as Ms. Ellmers
1314 said, we are going to be spending some time looking at how
1315 you do help with the solvency, and I want to ask you just one
1316 thing. My class, when we came into Congress, we were focused
1317 on waste, fraud and abuse. We did an entire project,
1318 Wasteful Washington Spending, and of course, Medicare
1319 spending continued to come into that picture, and we had
1320 example after example of wasteful and fraudulent spending and

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1321 the abuse of just millions of dollars. So do you think, in
1322 your opinion, do you think that the antiquated method, the
1323 fee-for-service method, is something that continues to make
1324 it possible for this continuation of waste, fraud and abuse
1325 every year and difficulty in running the traps on this and
1326 rooting it out?

1327 Mr. {Hackbarth.} Yes. We think that waste, fraud and
1328 abuse is a significant problem, particularly in some areas of
1329 the program. Earlier we were talking about home health care
1330 is an area where there is a lot, and where Medicare payments
1331 are really generous, and we think they are generous for home
1332 health care, that is almost an invitation to people who want
1333 to make a quick buck on Medicare.

1334 Mrs. {Blackburn.} A lot of quick bucks, it seems like.

1335 Mr. {Hackbarth.} A lot of quick bucks, and durable
1336 medical equipment is another area where we think there has
1337 been a fair amount of waste, fraud and abuse, and in part
1338 that is triggered by very attractive payment rates that bring
1339 in people who are more focused on making money than serving
1340 patients.

1341 Mrs. {Blackburn.} What would you say is the percent of

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1342 expenditures that are going out the door, those payments
1343 going out the door? What percent do you think are fraudulent
1344 payments?

1345 Mr. {Hackbarth.} We really haven't looked at that
1346 issue. I think the Government Accountability Office has made
1347 estimates that--

1348 Ms. {Blackburn.} Right. They have. I just didn't know
1349 if you kind of lined up with them or if you had another
1350 opinion of that.

1351 Let me ask you, looking at that same thought and
1352 thinking about the solvency and the financing mechanisms,
1353 AARP has done reports going back 1998, 1999 looking at
1354 merging A and B and then looking at the financing end of
1355 that. Where do you stand with those knowing that people are
1356 concerned? We hear about it every day--tell me what you know
1357 is going to happen with Medicare, are we really in danger of
1358 going bankrupt. And so as you put your reforms forward
1359 today, what do you think they will do in helping with the
1360 solvency? If we did your reforms, how long would it
1361 encourage the solvency of Medicare? How many more years
1362 would we get out of this?

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1363 Mr. {Hackbarth.} Well, that is a question better
1364 directed to the Medicare actuaries. What we have outlined is
1365 a package that would have a modest net reduction in Medicare
1366 spending on the order of about one-half of 1 percent so that,
1367 you know, \$2.5 or \$3 billion a year, \$25 or \$30 billion over
1368 10 years. Now, what that assumes is a 20 percent charge on
1369 supplemental insurance and that nobody modifies their
1370 decisions, beneficiaries don't change their decisions about
1371 purchasing supplemental insurance. If in fact beneficiaries
1372 start to say, oh, this new redesigned benefit means I don't
1373 have to buy supplemental insurance or they buy one that
1374 doesn't have first-dollar coverage, then those savings may
1375 increase and you might go from \$2.5 to \$3 billion a year to
1376 \$5 or \$6 billion a year.

1377 Ms. {Blackburn.} Well, yes, and that is always kind of
1378 the discussion we get into with whether we are using the
1379 static or the dynamic scoring ad the basis that people make
1380 their decisions on.

1381 I have one other question, but in the interests of time,
1382 Mr. Chairman, I will yield back my time and submit my third
1383 question.

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1384 Mr. {Pitts.} The Chair thanks the gentlelady and now
1385 recognizes the gentleman from Maryland, Mr. Sarbanes, for 5
1386 minutes for questions.

1387 Mr. {Sarbanes.} Thank you, Mr. Chairman. Thank you,
1388 Mr. Hackbarth.

1389 Could you just talk a little bit about the relationship
1390 between the proposed benefit design change that would impose
1391 a higher cost-sharing impact on a patient for a lower-value
1392 service and a lower cost share for a higher-value service,
1393 the relationship of that proposal to the change in
1394 reimbursement methodology vis-à-vis the providers of care,
1395 which is another place where we are looking at this high-
1396 value, low-value dynamic? In other words, you have services
1397 now that a primary care physician might be prepared to offer
1398 but there is really no meaningful reimbursement for it so
1399 there is no incentive to do it so you can envision a
1400 situation where there is a service that is not getting
1401 covered at all by Medicare and maybe want to re-look at that
1402 but then at the same time we want to examine then what the
1403 cost sharing with Medicare's new obligation would be. It
1404 seems to me those have got to be interrelated to some degree.

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1405 Mr. {Hackbarth.} So we think there are issues on both
1406 the patient cost-sharing side and the provider payment side,
1407 and I think at the SGR hearing a few weeks ago, the two of us
1408 talked about primary care services, which we think are high-
1409 value services that are often are underpaid under the
1410 existing Medicare fee schedule. So in the case of a primary
1411 care who has taken responsibility, for example, under a
1412 medical home to manage patients with multiple chronic
1413 illnesses, you know, ideally what you might have is lower
1414 cost sharing for really high-value services for the patient
1415 and richer payment for the physician for taking on this very
1416 important task of managing complicated patients. Right now,
1417 Medicare has fallen short on both the provider and the
1418 beneficiary side.

1419 Mr. {Sarbanes.} In that sense, it is kind of a double
1420 investment in redirecting or transitioning the emphasis of
1421 where the care happens and has to be premised on the idea
1422 that even that increased investment, which is a combination
1423 of higher reimbursement to the physician and lower cost
1424 sharing on the part of the patient, that we are going to see,
1425 it is going to yield savings down the road that justifies

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1426 both of those investments we are making.

1427 Mr. {Hackbarth.} Yes. Ideally, we are working both
1428 sides, the provider payment and the beneficiary benefit
1429 structure, and doing it in a synchronized way. That is how
1430 we get the maximum impact.

1431 Mr. {Sarbanes.} Thank you.

1432 Mr. {Pitts.} The Chair thanks the gentleman and now
1433 recognizes the gentleman from Louisiana, Dr. Cassidy, 5
1434 minutes for questions.

1435 Dr. {Cassidy.} Hi, Mr. Hackbarth. I will kind of scoot
1436 over so we can see each other.

1437 I always enjoy your testimony. I always consider it
1438 very thoughtful.

1439 Now, there does seem to be, though--I always make the
1440 point that people in Washington have kind of a centrally
1441 planned economy view of how we do things, and if you will, as
1442 great as your work is, it truly is trying to anticipate lots
1443 of very unique situations coming up for rules that with that
1444 anticipation work to very unique situations. The very
1445 premise seems untenable. Do you see my point?

1446 Mr. {Hackbarth.} Well, yes and no. On the one hand, I

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1447 do believe, and I think we have talked about this in the
1448 past, that giving Medicare beneficiaries options, for
1449 example, to enroll in a Medicare Advantage plan, a private
1450 health plan, is a very important thing to do, and I think you
1451 agree with that as well. On the other hand, I must confess,
1452 when I hear people criticize Medicare for its administered
1453 price system, it sets me a little bit on edge because I know
1454 better than most people the problems with administered
1455 prices. I have spent many, some would say too many hours
1456 working on these issues in my career. But when I look at
1457 Medicare pricing compared to pricing in the private sector,
1458 our system looks pretty good.

1459 Dr. {Cassidy.} No, believe me, I am not defending the
1460 private sector, and I actually like your proposal that if you
1461 put these physicians at two-sided risk with some sort of
1462 accountability as to outcomes and have the quote, unquote,
1463 activated patient, that is the better way to go. My concern
1464 is that if there is an innovation which is disruptive, it
1465 gives you a better outcome at a lower cost. It will be 3
1466 years later before that may be priced accordingly or even
1467 given a code.

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1468 Mr. {Hackbarth.} And, you know, overall, my goal is to
1469 decentralize decisions, put as many decisions as possible in
1470 the hands of physicians and patients, provided that there is
1471 accountability for the results, both quality and cost.

1472 Dr. {Cassidy.} Now, a conversation just to revisit we
1473 have probably had before, the ACO, I think you rightly put
1474 the physician-patient relationship at the center of our
1475 ability to improve outcomes and control costs. But I see a
1476 lot of what we are proposing are actually on the
1477 suprastructure, if you will. Here is the patient, physician,
1478 but here is the administrative cost and here is the ACO,
1479 etc., and that actually seems to be insulating or denying
1480 responsibility for this integral relationship. Any thoughts
1481 on that?

1482 Mr. {Hackbarth.} Well, so let us use ACOs as a
1483 potential framework for decentralizing decisions to
1484 physicians and patients, and as you know, from prior
1485 conversations, I believe in that. You know, right now we
1486 have got an ACO structure which I think is a step in the
1487 right direction but has some problems with it, and one that I
1488 would highlight in this context is, Medicare beneficiaries

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1489 don't share in any of the savings from an ACO. All of the
1490 talk is about how the physicians, the hospitals and the
1491 government share in the savings but there are no real rewards
1492 for Medicare beneficiaries. We think across the board we
1493 need to work on improving provider payment and bringing
1494 Medicare beneficiaries appropriately into those discussions
1495 and allowing them to share in savings when they go to high-
1496 value providers.

1497 Dr. {Cassidy.} And we are totally in agreement on that.
1498 I think one thing I would also point out is that if we are
1499 going to bring this down to the smaller practice, I am not
1500 quite sure how an ACO would work for a four-person practice
1501 in a rural area, if only because you are only going to get
1502 settled up on the positive things you have done 2 years after
1503 you have done it. If you are in a cash-flow-dependent
1504 practice, you probably don't have the wherewithal to wait 2
1505 years to have a settling up.

1506 Mr. {Hackbarth.} Although one of the ACO models does
1507 involve an advanced payment for just that reason, the
1508 physician-sponsored ACOs. You know, I think it is too early
1509 to predict exactly how ACOs will develop, especially in

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1510 sparsely populated areas like rural areas, but about half of
1511 the current ACOs involve either Critical Access Hospitals or
1512 Community Health Centers and deal with relatively challenging
1513 care delivery systems.

1514 Dr. {Cassidy.} I accept that, but we are going so far
1515 down the road in terms of planning and implementing political
1516 and bureaucrat capital in putting these in place. Not
1517 knowing where they are going to go and seeing that there are
1518 flaws inherent in them makes me troubled. I mean, is that
1519 unique relationship going to be preserved when, again, we
1520 just don't know where it is going.

1521 Mr. {Hackbarth.} Well, we certainly believe that
1522 preserving that relationship is really important, vital,
1523 essential, and I may be a little bit more optimistic than you
1524 are that in fact the movement is in the right direction, but
1525 I think we have to be vigilant about it.

1526 Dr. {Cassidy.} I am out of time. I yield back. Thank
1527 you.

1528 Mr. {Pitts.} The Chair thanks the gentleman and now
1529 recognizes the gentleman from Florida, Mr. Bilirakis, 5
1530 minutes for questions.

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1531 Mr. {Bilirakis.} Thank you, Mr. Chairman. I appreciate
1532 it very much.

1533 Mr. Hackbarth, your testimony really touches on the
1534 importance of transparency and predictability in pricing and
1535 out-of-pocket expenses for seniors in the Medicare program.
1536 No other industry I know of would facilitate customers not
1537 knowing the cost of service until after it has been
1538 performed. Can you explain your thoughts on the importance
1539 of out-of-pocket predictability as it relates to the reforms
1540 you have presented here today or even for future reforms to
1541 the program?

1542 Mr. {Hackbarth.} Well, Mr. Bilirakis, the most
1543 important thing is that we know from focus groups with
1544 beneficiaries that they find the current benefit structure
1545 confusing and more than a little bit frightening because they
1546 don't feel like they can predict what is going to happen,
1547 what the bill is going to be if they get sick or even when
1548 they go to a physician office because, as Dr. Burgess said,
1549 it is 20 percent of what. We don't know. And so what we
1550 have advocated is a focus on simplification and protection
1551 against overall costs, and we think that that will be very

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1552 reassuring to Medicare beneficiaries and perhaps over time
1553 will influence their decisions about whether they need
1554 supplemental insurance and, if so, what kind they buy, and
1555 that would be a good thing for Medicare.

1556 Mr. {Bilirakis.} And you of course agree that seniors
1557 should be more active participants?

1558 Mr. {Hackbarth.} Absolutely.

1559 Mr. {Bilirakis.} Thank you. You reference in your
1560 testimony, and I think the gentlelady from the Virgin Islands
1561 referred to this, but your testimony, the suggestion that
1562 Congress should consider giving the power to the Secretary to
1563 reduce cost sharing on services if evidence indicates that
1564 doing so would reduce Medicare spending or lead to better
1565 health care outcomes, and vice versa. Can you elaborate on
1566 that?

1567 Mr. {Hackbarth.} Well, I am not sure I have a whole lot
1568 new to say on that, but we do think that services are of
1569 different value to patients. Certainly we know that some
1570 services are really important for beneficiaries with chronic
1571 illness, and we don't want cost sharing at the point of
1572 service to be a barrier to that care because patients will be

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1573 worse off with worse health outcomes, and Medicare will incur
1574 higher long-run costs. And so as opposed to a crude approach
1575 to cost sharing which just says same rate for everything, you
1576 know, 20 percent across the board, we think we can do better
1577 than that and be smarter about it and have better results for
1578 patients.

1579 Mr. {Bilirakis.} Thank you very much. I yield back,
1580 Mr. Chairman.

1581 Mr. {Pitts.} The Chair thanks the gentleman and now
1582 recognizes the gentleman from New Jersey, Mr. Lance, 5
1583 minutes for questions.

1584 Mr. {Lance.} Thank you, Mr. Chairman. I would be happy
1585 to yield my time to Dr. Burgess.

1586 Dr. {Burgess.} I thank the gentleman for yielding.

1587 Mr. Hackbarth, just a couple of follow-up things, and
1588 thank you for mentioning HCFA. It brought back memories of
1589 when I thought HCFA was a four-letter word when I was in
1590 practice. Back in the 1990s with the passage of the Kennedy-
1591 Castelbaum bill, that behemoth that gave us HIPAA, but it
1592 also allowed for the first time the sale in this country of
1593 medical savings accounts, but if I recall correctly, they

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1594 were very careful to keep that type of insurance out of the
1595 Medicare system. Is that correct?

1596 Mr. {Hackbarth.} Yes, I think that is correct.

1597 Dr. {Burgess.} Well, here is my question, and I still
1598 have a problem with the concept that--and let me very honest
1599 with you here. I have got someone in my household who is
1600 going to turn 65 this year, and we are just deluged with
1601 stuff from people wanting to sell a supplemental policy. So
1602 I can certainly sympathize with the person who looks at all
1603 of this information, and oh, my god, I want to do the right
1604 thing, I want to be prepared for bad things that could happen
1605 so I will make this investment. It is hard for me to believe
1606 that that is an erroneous activity for that person for them
1607 to be engaged in that. You kind of indicate in your
1608 testimony that a lot of times what they are paying in for
1609 that supplemental is far in excess of anything they would get
1610 from a benefit from the supplemental payment. Why don't we
1611 make it easy to put additional dollars away for their health
1612 care in a Medicare health savings account that would be
1613 available them to draw on and need if there were costs over
1614 and above what the Medicare benefit would provide them?

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1615 Mr. {Hackbarth.} Dr. Burgess, we haven't looked
1616 specifically at the issue of medical savings accounts for
1617 Medicare beneficiaries, so I don't have a MedPAC view on
1618 that.

1619 Dr. {Burgess.} Let me just offer you an observation.
1620 We talk about 10,000, 12,000 people a day entering Medicare.
1621 There are going to be more and more people who enter Medicare
1622 with a health savings account that actually has cash in it
1623 that was not used prior to the time of entering into
1624 Medicare. Are you looking over the horizon at all and trying
1625 to figure out how do you deal with--Bill Cassidy called them
1626 the activated patient. That is exactly right. Governor
1627 Mitchell Daniels when he provided his Healthy Indiana program
1628 to State employees essentially was a high-deductible health
1629 plan coupled with a health savings account, he made the
1630 observation that something magic happens when people spend
1631 their own money for health care, even if it wasn't their own
1632 money in the first place. But you have got these people
1633 arriving into Medicare, aging into the Medicare system with a
1634 large health savings account that they are holding. Why not
1635 allow them to participate in their care?

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1636 Mr. {Hackbarth.} Well, this is an issue of personal
1637 interest since I am going to be 62 and actually my wife and I
1638 have a health savings account. We have been insured under a
1639 high-deductible plan for quite some time now. So it is an
1640 important issue. It is not one that we have looked at at
1641 this point.

1642 Dr. {Burgess.} Let me just make another observation. I
1643 mean, I know fee-for-service gets a bad name and a bad rap in
1644 a lot of ways, and Dr. Cassidy referenced the small practice
1645 in rural setting. I always allude to the solo practitioner
1646 in Muleshoe, Texas, who really can't participate in an ACO.
1647 Yes, they can be acquired by a network. But, you know, every
1648 time I think of accountable care organizations, I have to ask
1649 myself, accountable to whom, because as Dr. Cassidy correctly
1650 pointed out, there are significant--because of the risk
1651 factor, there is a significant cash amount that needs to be
1652 available that is generally not available to the small and
1653 individual practice so that there is someone else who is
1654 going to have to be, if you will, a financial or fiscal
1655 partner in that endeavor. So it just begs the question,
1656 accountable to whom? Is it accountable to the hospital? If

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1657 the doctor is accountable to an accountable care
1658 organization, is that really accountable to the hospital or
1659 to the government or to a health plan? It kind of begs the
1660 question, are they still accountable to the patient, and just
1661 speaking from a professional standpoint, I am worried about
1662 the direction in which that is going.

1663 Mr. {Hackbarth.} Well, there are to be sure lots of
1664 complicated issues that need to be examined and resolved
1665 around the development of ACOs. I think it is a step in the
1666 proper direction. I say that because I really am looking for
1667 structures that decentralize decisions so that clinicians and
1668 patients can make them together subject to accountability on
1669 quality and cost. Now, exactly how you set the cost and all
1670 the issues about the flow of the money, those are really
1671 important things, and I don't mean to diminish their
1672 importance, but if the goal is getting the federal government
1673 out of intrusion into medical practice, structures like this
1674 I think need to be part of the solution so let us focus on
1675 making them better as opposed to undermining them.

1676 Dr. {Burgess.} Thank you, Mr. Chairman. I will yield
1677 back, and I thank the gentleman from New Jersey for yielding

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1678 the time.

1679 Mr. {Pitts.} The Chair thanks the gentleman. We have a
1680 unanimous-consent request.

1681 Mr. {Pallone.} Mr. Chairman, I ask unanimous consent to
1682 submit for the record various statements from the United
1683 Steel Workers, California Health Advocates, testimony on
1684 behalf of the UAW, a statement from the National Association
1685 of Home Care and Hospice, and a statement from the National
1686 Committee to Preserve Social Security and Medicare, and I
1687 believe you have all these.

1688 Mr. {Pitts.} Yes. Without objection, so ordered.

1689 [The information follows:]

1690 ***** COMMITTEE INSERT *****

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|
1691 Mr. {Pitts.} That concludes the round of questioning.
1692 We have some members who have additional questions. I remind
1693 members they have 10 business days to submit any additional
1694 questions for the record, and I ask the witness to please
1695 respond to the questions promptly.

1696 Thank you very much for your time, your testimony this
1697 morning. And members should submit their questions by the
1698 close of business on Thursday, April 25.

1699 Thank you, and without objection, the subcommittee is
1700 adjourned.

1701 [Whereupon, at 11:39 a.m., the subcommittee was
1702 adjourned.]