

**Rep. Joseph R. Pitts**  
**Opening Statement**  
**Energy and Commerce Subcommittee on Health**  
**Hearing on “A 21st Century Medicare: Bipartisan Proposals to Redesign the**  
**Program’s Outdated Benefit Structure”**  
**June 26, 2013**

The Subcommittee will come to order.

The Chair will recognize himself for an opening statement.

Nearly 50 million seniors rely on the Medicare program for their health care, and that number may grow to 63 million Americans by 2020 and 81 million by 2030.

Medicare’s traditional benefit design mirrored the private insurance products, namely Blue Cross Blue Shield plans, available in the mid-1960s. While the private insurance market has undergone significant changes in the last fifty years, Medicare’s traditional benefit structure has remained fundamentally the same.

Unlike most private insurance today, which has a single deductible for all medical services, traditional Medicare has separate deductibles and copayments for Part A, hospital services, and Part B, physician and outpatient services. The program also charges separate copayments for Part A and Part B services.

Today, seniors face great uncertainty about what their out-of-pocket costs will be. Generally, Medicare requires a 20% copayment – but without knowing the total cost for a doctor’s visit, a hospitalization, or a procedure or test, seniors don’t know what that 20% means in dollars until after a service is delivered.

With no cap on out-of-pocket spending a beneficiary can incur, and confusion about the lack of coordination between Parts A and B, nine out of ten Medicare beneficiaries purchase supplemental insurance.

On April 11, 2013, the Subcommittee held a hearing entitled “Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare’s Benefit Design,” at which MedPAC Chairman Glenn Hackbarth discussed ways to modernize and improve Medicare’s traditional benefit design.

As I said at that hearing, everything about our health care system has changed dramatically since 1965. Today's standards of care, and the tests, treatments, and drugs we have access to were not even dreamed of when the program was created.

Our expectations have changed, as well. Fifty years ago, insurance protected us from catastrophic hospital costs incurred as a result of diseases which were most likely fatal. With the medical breakthroughs we've experienced in the ensuing decades, many of those diseases have become chronic conditions, and we expect our insurance to help us manage them accordingly.

Seniors deserve an insurance product that reflects the current health care system, not that of the last century.

Today's hearing builds on MedPAC's recommendations, by bringing in policy experts to further explore how we can make the program work better for our seniors.

I'd like to thank our witnesses for being here today. I look forward to their comments on some of the reforms we discussed at the previous hearing, such as combining Parts A and B under a unified cost-sharing structure, instituting a cap on out-of-pocket spending to protect beneficiaries from the threat of medical bankruptcy, incentivizing high-value care, and others.

Thank you, and I yield the remainder of my time to Rep. \_\_\_\_\_.