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ONE HUNDRED THIRTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**  
COMMITTEE ON ENERGY AND COMMERCE  
2125 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-6115  
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July 24, 2013

Mr. Thomas P. Miller  
Resident Fellow  
American Enterprise Institute  
1150 17th Street, N.W.  
Washington, D.C. 20036

Dear Mr. Miller:

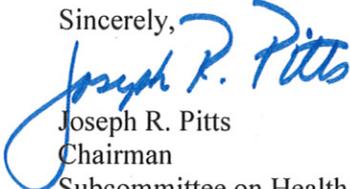
Thank you for appearing before the Subcommittee on Health on Wednesday, June 26, 2013, to testify at the hearing entitled "A 21st Century Medicare: Bipartisan Proposals to Redesign the Program's Outdated Benefit Structure."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Wednesday, August 7, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to [Sydne.Harwick@mail.house.gov](mailto:Sydne.Harwick@mail.house.gov).

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

  
Joseph R. Pitts  
Chairman  
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

## Attachment—Additional Questions for the Record

### The Honorable Gus Bilirakis

1. One of the great challenges of health care is the issue of price transparency. Health care is one of the biggest sectors of our economy where no one knows the cost of a service. Under a co-pay system, a patient could know the cost of a medical service in advance, but that cost does not necessarily represent the total actual cost of the service. Under a co-insurance system, a patient might not know the cost of a service until after the service is performed. When designing a new benefit structure, how can we increase the level of transparency in the system so beneficiaries can know what their costs will be before they even visit the doctor?
2. Is it worthwhile to have multiple Medicare plans in the marketplace? CMS could establish an actuarial value and allow various plans of different premiums/deductibles/cost-shares. This would allow seniors to choose a plan that fits their lifestyle and health status rather than a one-size-fits-all plan.
3. Traditional Medicare Fee for Service operates in two different silos, Part A & B, without either part talking to each other. Medicare Advantage provides a comprehensive benefit with coordination between hospital and outpatient settings. Do we have data evaluating Medicare Advantage against traditional fee-for service? Does Medicare Advantage provide lower costs and better outcomes compared to traditional fee-for-service? What lessons from Medicare Advantage can we apply to redesigning traditional Medicare?
4. There is concern that MediGap plans driving up cost, providing less benefit for seniors, and we should think about alternatives to these plans. What if we gave everyone an HSA? Millions of Americans have an HSA today and they will age into the Medicare population. Do we have data, on average, how much seniors would have in an HSA as they entered Medicare, or could have, if HSA's were more widespread and used over a lifetime? If seniors had HSA's with a lifetime of savings in it, there would be less need for MediGap policies, and seniors would be better equipped to cover sudden health care spending spikes.