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4 KEEPING THE PROMISE: ALLOWING SENIORS TO KEEP THEIR MEDICARE

5 ADVANTAGE PLANS IF THEY LIKE THEM

6 THURSDAY, MARCH 13, 2014

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 10:00 a.m.,

12 in Room 2123 of the Rayburn House Office Building, Hon.

13 Joseph R. Pitts [Chairman of the Subcommittee] presiding.

14 Members present: Representatives Pitts, Burgess,

15 Whitfield, Shimkus, Murphy, Blackburn, Gingrey, Lance,

16 Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Pallone,

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17 Engel, Green, Barrow, Christensen, and Waxman (ex officio).  
18 Staff present: Clay Alspach, Chief Counsel, Health; Sean  
19 Bonyun, Communications Director; Matt Bravo, Professional  
20 Staff Member; Noelle Clemente, Press Secretary; Paul Edattel,  
21 Professional Staff Member, Health; Sydne Harwick, Legislative  
22 Clerk; Robert Horne, Professional Staff Member, Health; Chris  
23 Sarley Policy Coordinator, Environment & Economy; Heidi  
24 Stirrup, Health Policy Coordinator; Josh Trent, Professional  
25 Staff Member, Health; Tom Wilbur, Digital Media Advisor;  
26 Jessica Wilkerson, Legislative Clerk; Ziky Ababiya, Staff  
27 Assistant; Phil Barnett, Staff Director; Eddie Garcia,  
28 Professional Staff Member; Kaycee Glavich, GAO Detailee; Amy  
29 Hall, Senior Professional Staff Member; Karen Lightfoot,  
30 Communications Director and Senior Policy Advisor; and Karen  
31 Nelson, Deputy Committee Staff Director for Health

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|  
32           Mr. {Pitts.} The subcommittee will come to order. The  
33 chair will recognize himself for an opening statement.

34           Nearly 15 million seniors, or almost 30 percent of  
35 Medicare beneficiaries, have chosen to enroll in a Medicare  
36 Advantage plan, an alternative to fee-for-service or  
37 traditional Medicare. Medicare Advantage or MA plans offer  
38 benefits not provided under traditional Medicare, such as  
39 reduced cost-sharing, vision and dental coverage, preventive  
40 care, and care coordination services. Numerous studies show  
41 that MA enrollees enjoy better health outcomes and receive  
42 higher quality care than those in traditional Medicare.

43           So who are MA beneficiaries? Medicare Advantage covers  
44 a disproportionate share of low-income and minority seniors  
45 when compared to traditional fee-for-service Medicare. Four  
46 in ten seniors with MA plans have incomes of \$20,000 or less.  
47 Medicare Advantage is fundamentally about offering seniors  
48 the choice of better healthcare through traditional Medicare.  
49 Beneficiaries choose the plans that best meet their  
50 individual health needs. And, according to the latest CMS  
51 National Health Expenditures data, more than half of new

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52 Medicare enrollees are choosing Medicare Advantage plans.

53 We should be encouraging seniors to take control of  
54 their healthcare and expanding this proven program. Instead,  
55 this Administration's policies are harming seniors by  
56 reducing their choices of high quality care through a series  
57 of cuts to the Medicare program that began with the  
58 Affordable Care Act.

59 According to the Congressional Budget Office, ObamaCare  
60 cut more than \$700 billion from Medicare and spent the money  
61 on new government programs not for seniors. CBO also has  
62 said more than \$300 billion of those cuts come from Medicare  
63 Advantage. Last year, CMS imposed regulatory cuts of 4 to 6  
64 percent on MA plans, resulting in benefit reductions of \$30  
65 to \$70 per senior per month.

66 And on February 21, 2014, CMS released its 2015 Advance  
67 Notice outlining changes to Medicare Advantage payment  
68 policies, which an Oliver Wyman study estimates will result  
69 in an additional cut of nearly 6 percent. This newest cut is  
70 projected to cause seniors to lose an additional \$35 to \$75  
71 per month in benefits. According to experts, these  
72 cumulative cuts from the Democrats' policies on seniors could

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73 result in ``plan exits, reductions in service areas, reduced  
74 benefits, provider network changes, and MA plan  
75 disenrollment.''

76       The week before last, this subcommittee held a hearing  
77 on the Administration's assault on Medicare Part D  
78 prescription drug plans. Now, we are learning about more  
79 crippling cuts to Medicare Advantage. Why is the  
80 Administration dead set on pushing policies that harm seniors  
81 and using their Medicare program as a piggy bank to fund  
82 other healthcare programs?

83       Today, we will hear from a number of Members who have  
84 authored legislation that would improve the Medicare  
85 Advantage program for seniors. We also have witnesses who  
86 can speak to the harm that this Administration's policies  
87 have done to them.

88       I would like to thank all of our witnesses for appearing  
89 today. I will yield at this point the remainder of my time  
90 to vice chair of the subcommittee, Dr. Burgess.

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

92 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
93           Dr. {Burgess.} I want to thank the chairman for  
94 yielding.

95           We do spend a lot of time in Congress talking about the  
96 problems in healthcare. The problem is we are so busy  
97 triaging the mistakes that we don't think about the things  
98 that are actually working. And Medicare Advantage is one of  
99 those things that is actually working.

100          What do we always talk about? We talk about disease  
101 management, coordinated care. We have talked about that in  
102 this committee in a bipartisan fashion for a long time, but  
103 guess what? Medicare Advantage plans are delivering on that  
104 promise. The President, however, decided to take money away  
105 from a working program in order to fund one that is  
106 dysfunctional. The President sold the Affordable Care Act on  
107 a foundation of false promises. You can keep your plan:  
108 false. You can keep your doctor: also not true.

109          President Obama told seniors he would use the money from  
110 Medicare to fund the Affordable Care Act, and at the same  
111 time improve Medicare for beneficiaries. In reality, these  
112 payment cuts are not going back to Medicare but instead they

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113 are funding other provisions of the Affordable Care Act.  
114 Along with less money to Medicare Advantage plans, the  
115 Affordable Care Act burdened plans with additional  
116 requirements.

117 The most recent proposed cuts to Medicare Advantage are  
118 part of a historic strategy of provider cuts that have always  
119 backfired. The sustainable growth rate is the leading  
120 example. It limits access for seniors and doesn't reduce  
121 cost. It is time for the Administration to shift gears and  
122 change strategies. Don't fix what is not broken. It is time  
123 for the Administration to start addressing the real problem,  
124 the Affordable Care Act, and not look for problems that are  
125 nonexistent.

126 I yield back to the chairman.

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

128 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
129           Mr. {Pitts.} The chair thanks the gentleman and now  
130 yields 5 minutes for an opening statement to the ranking  
131 member, Mr. Pallone.

132           Mr. {Pallone.} Thank you, Chairman Pitts.  
133 Unfortunately, I have to begin today's hearing expressing my  
134 disappointment in the tactics and process from your side of  
135 the aisle. This hearing has morphed from the future of  
136 Medicare Advantage, or MA, into what your side is now calling  
137 a legislative hearing, and we clearly have different  
138 definitions of what a legislative hearing should look like.

139           You have invited seven Republican Members to come and  
140 talk about bills they have introduced or plan to introduce  
141 that will affect Medicare in some way. When we were told of  
142 this development, there were requests from staff on whether  
143 any Democratic bills on Medicare could be included today and  
144 those requests were ignored. In fact, I have a bill on Part  
145 D program integrity that is very similar to one presented,  
146 but for some reason, that bill was not given any  
147 consideration.

148           So, Mr. Chairman, one bill in particular is quite

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149 egregious. It attempts to gut the coverage provisions of the  
150 Affordable Care Act in order to provide billions of dollars  
151 to private insurance companies. The others are not new ideas  
152 from Republicans; they involve allowing individuals to switch  
153 to high deductible health plans which do nothing but worsen  
154 the risk pool for those in comprehensive MA plans.

155 Another bill would reinstate the second enrollment  
156 period for seniors, an issue that has already been litigated  
157 and determined to be confusing and unhelpful to  
158 beneficiaries.

159 And I can go on and on about my concerns here, but most  
160 importantly, I wish we could hear from substantive witnesses  
161 today on how these bills would weaken--or as the other side  
162 claims, strengthen--the MA program, but unfortunately, we  
163 were not given that opportunity. So I hope that if the  
164 chairman intends to move forward on any of these bills, that  
165 the Administration, stakeholders, and Democratic staff would  
166 have an opportunity to weigh in. I don't have to remind you  
167 that recent history has shown that nothing becomes law out of  
168 this committee without bipartisanship.

169 While the majority of Medicare's 52 million

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170 beneficiaries are in the traditional federally administered  
171 Medicare program, MA offers beneficiaries an alternative  
172 option to receive their Medicare benefits through private  
173 health plans. MA has become fairly popular among seniors  
174 with more than 1/4 of all beneficiaries now enrolled in such  
175 plans across the country.

176         The ACA included quality improvements of MA plans by  
177 rewarding plans that deliver high-quality care with bonus  
178 payments. Incentivizing quality patient care over quantity  
179 of services provided is key to improving health outcomes and  
180 reducing the rising cost of healthcare. The bottom line is  
181 the ACA reined in a program whose costs were excessive and  
182 put the program on a more sustainable footing. Since passage  
183 of the Affordable Care Act, MA enrollment has increased by  
184 nearly 1/3, premiums have dropped by nearly 10 percent, and  
185 over 1/3 of MA contracts will receive 4 or more stars, an  
186 increase from 28 percent in 2013.

187         Despite warning cries to the contrary, the program is  
188 stronger than ever. Now, today, we will hear from some  
189 witnesses about a study commissioned by the plans themselves.  
190 They will claim that CMS' recent proposed cuts could

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191 devastate the MA market, but I would like to point out that  
192 these are not new cuts; these were expected cuts that bring  
193 MA plan payments in line with fee-for-service payments as  
194 required by law. And since by law MA plans are paid based on  
195 overall growth of Medicare, it is no surprise that when  
196 healthcare spending in Medicare slows, payments to MA plans  
197 will follow. And we should all think that is a good thing,  
198 especially those who continually take aim at the percentage  
199 of federal spending on healthcare.

200           So not only were plans prepared for these reductions,  
201 Wall Street doesn't seem to think the outlook is as dire. In  
202 fact, some company stocks skyrocketed because the truth is,  
203 as more and more baby boomers age into Medicare, and  
204 hopefully, unless the Republicans mess it up, a permanent  
205 replacement for the SGR is passed into law, the MA program  
206 will become even more robust and will continue to be an area  
207 of growth for insurance companies.

208           Regardless of the talking points from the other side and  
209 industry, I continue to believe that removing plan  
210 overpayments is the right policy for Medicare. To reverse  
211 course would raise costs for taxpayers and all Part B

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212 beneficiaries, drain from the solvency of the trust fund, and  
213 expand beneficiary inequities that disadvantage the  
214 overwhelming majority of Medicare beneficiaries who remain in  
215 fee-for-service.

216         So I look forward to hearing from our second panel  
217 today, specifically from Ms. Stein and Mr. Van de Water,  
218 because a debate about how much we pay private insurance  
219 companies is overshadowing some important aspects of CMS'  
220 work in protecting beneficiaries. We should all work  
221 together to strengthen and improve the program and not weaken  
222 it.

223         Thank you, Mr. Chairman.

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

225         \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
226 Mr. {Pitts.} The chair thanks the gentleman and now  
227 recognizes the gentleman from Florida, Mr. Bilirakis, for 5  
228 minutes for an opening statement.

229 Mr. {Bilirakis.} Thank you very much. I appreciate it,  
230 Mr. Chairman.

231 Thanks for holding this important hearing on how to  
232 protect Medicare Advantage. My bill, H.R. 3392, the Medicare  
233 Part D Patient Safety and Drug Abuse Prevention Act, will  
234 reduce fraud and abuse without negatively impacting Medicare  
235 beneficiaries by enacting cost-saving measures employed not  
236 only by TRICARE and the State Medicaid programs but also by  
237 private industry.

238 H.R. 3392 creates a safe pharmacy access program to  
239 establish a single point-of-sale pharmacy system for the  
240 dispensing of controlled substances for high-risk  
241 beneficiaries. This will directly address the issue of  
242 doctor and pharmacy shopping where individuals go to multiple  
243 locations to fill multiple prescriptions.

244 I would like to thank my cosponsor, Mr. Ben Lujan, and  
245 then I also want to yield now the balance of my time to Dr.

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246 Cassidy.

247 Thank you, Mr. Chairman.

248 [The prepared statement of Mr. Bilirakis follows:]

249 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
250 Dr. {Cassidy.} Thank you, Mr. Bilirakis. Thank you,  
251 Mr. Chairman.

252 I submit for the record a letter to the CMS that  
253 Mr. Barrow and I over 200 of our congressional colleagues  
254 have signed.

255 We are concerned about the proposed cuts to the MA plan  
256 and the negative impact it will have on seniors. Over 15  
257 million seniors rely on Medicare Advantage, almost 1/3 of  
258 Medicare beneficiaries. These plans are popular because they  
259 have been proven to contain costs and improve enrollee health  
260 outcomes by focusing on prevention and disease management.  
261 CMS is planning to cut MA plans for overall seniors by 5.9  
262 percent in 2015. In Louisiana that averages out that the MA  
263 beneficiary will have about a \$55 to \$65 cut per month, which  
264 of course is \$660 to \$780 per year in higher premiums, higher  
265 cost-sharing, and lower benefits for about 200,000 MA  
266 beneficiaries in my State.

267 In response, Members of Congress are coming out of the  
268 woodwork to say to CMS stop these cuts, protect Medicare  
269 Advantage, protect seniors.

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270 Now, if Mr. Bilirakis will allow me to, I will yield 1

271 minute to the gentleman from Georgia, Mr. Barrow.

272 [The prepared statement of Dr. Cassidy follows:]

273 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
274           Mr. {Barrow.} Thank you, Dr. Cassidy, for yielding  
275 time, and thank you for your partnership on this issue.

276           Mr. Chairman, Georgia is home to hundreds of thousands  
277 of Medicare Advantage beneficiaries who are worried about the  
278 stability of the program. The proposed cuts to Medicare  
279 Advantage would amount to a 5.9 percent cut. These cuts will  
280 reduce benefits and increase premiums by \$35 to \$75 per month  
281 for our Nation's 15 million seniors with Medicare Advantage.  
282 Further cuts to Medicare Advantage would dramatically alter  
283 the standard of care that folks have come to rely on. That  
284 is why, as of today, 204 of our colleagues have joined  
285 Dr. Cassidy and me to warn Administrator Tavenner against  
286 these proposed cuts.

287           Mr. Chairman, thank you for calling this hearing. I  
288 look forward to learning much from the witnesses and working  
289 with you to strengthen this vital program.

290           With that, I yield back the balance of my time to Dr.  
291 Cassidy.

292           [The prepared statement of Mr. Barrow follows:]

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293 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|

294           Dr. {Cassidy.} Would the gentleman yield for one second  
295 just to welcome our panel and my roommate Mr. Paulsen?

296           Mr. {Pitts.} Thank you. And without objection, the  
297 letter that Dr. Cassidy submitted will be entered into the  
298 record.

299           [The information follows:]

300           \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|

301           Mr. {Pitts.} We have two panels today. The first is a  
302 Member panel and I will introduce them at this time and they  
303 will speak in this order. First, Hon. Erik Paulsen, Member  
304 of Congress from Minnesota; then Hon. Jeff Denham, Member of  
305 Congress from California; Hon. Dennis Ross, Member from  
306 Florida; Hon. Keith Rothfus, Member from Pennsylvania; and  
307 Hon. Jackie Walorski, Member from Indiana.

308           Thank you very much for coming today. Your written  
309 testimony will be made part of the record. You will be each  
310 given 5 minutes for your opening statement, so the chair  
311 recognizes Mr. Paulsen for 5 minutes.

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|  
312 ^STATEMENTS OF HON. ERIK PAULSEN, A REPRESENTATIVE IN  
313 CONGRESS FROM THE STATE OF MINNESOTA; HON. JEFF DENHAM, A  
314 REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; HON.  
315 DENNIS ROSS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF  
316 FLORIDA; HON. KEITH ROTHFUS, A REPRESENTATIVE IN CONGRESS  
317 FROM THE STATE OF PENNSYLVANIA; AND HON. JACKIE WALORSKI, A  
318 REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

|  
319 ^STATEMENT OF HON. ERIK PAULSEN

320 } Mr. {Paulsen.} Thank you, Mr. Chairman. And, Chairman  
321 Pitts and Ranking Member Pallone, I want to thank you for  
322 holding this hearing today to ensure that our seniors and  
323 their Medicare Advantage (MA) plans are protected from  
324 unnecessary cuts.

325 I have received many calls and emails and letters from  
326 my constituents, my seniors in my district, who are concerned  
327 about cuts to the Medicare Advantage program and the impact  
328 that it could have on their healthcare plans.

329 The Medicare Advantage program is a resounding success

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330 in providing coordinated care for seniors with better  
331 quality, more choices, and greater savings for millions of  
332 Americans. Over 175,000 seniors in Minnesota are enrolled in  
333 an MA plan, including more than 50,000 in my congressional  
334 district alone. More than half of Medicare-eligible seniors  
335 in my district have opted to enroll in MA plans rather than  
336 the traditional fee-for-service system.

337 Nationwide, millions of Medicare beneficiaries have  
338 chosen a Medicare Advantage plan because they value access to  
339 better quality of care, innovative services, and additional  
340 benefits. The MA program enjoys high patient satisfaction  
341 and will reduce the cost of Medicare in the long run by  
342 providing evidence-based, coordinated care for our seniors.

343 Unfortunately, the future viability of the MA program is  
344 at risk. The MA program is facing ObamaCare-mandated payment  
345 cuts, the health insurance tax, and the coding intensity cut  
346 in last year's fiscal cliff deal. The latest threat is the  
347 12 percent cut in regulatory cuts that have been proposed the  
348 last 2 years, including a 6 percent cut to plans this year.  
349 Seniors in my district could pay as much as \$900 more per  
350 year as a result of these cuts. Many might lose benefits,

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351 and some could lose their plan completely.

352           The Administration is also attacking Medicare  
353 Advantage's innovative delivery system reforms, like in-home  
354 risk assessments, that have been absent in fee-for-service.  
355 Home risk assessments are clinical encounters in a  
356 beneficiary's home designed to prevent, to detect, and to  
357 treat chronic diseases to reduce hospital admissions,  
358 decrease readmissions, and improve the overall quality of  
359 life for seniors.

360           And instead of increasing costs for seniors and  
361 hindering plans' ability to utilize innovative models of  
362 care, Congress should be providing more flexibility to plans  
363 and make it easier for seniors to participate in MA-like  
364 plans.

365           That is why I have authoring legislation, Mr. Chairman,  
366 H.R. 4177, to allow Medicare beneficiaries to contribute  
367 their own money to their Medicare Savings Accounts, these  
368 MSAs. Medical Savings Accounts are health savings accounts  
369 for Medicare Advantage plans. They allow seniors to utilize  
370 money in the accounts to pay for healthcare costs, including  
371 some costs that aren't covered by Medicare.

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372           Right now, seniors can't contribute their own money to  
373 their MSA like they can to a healthcare savings account. But  
374 by giving seniors more flexibility with these accounts, we  
375 will empower them to take charge of their own healthcare  
376 decisions. And this will strengthen the Medicare Advantage  
377 program and it will reduce healthcare costs for seniors and  
378 the system in the long-term. I encourage the committee to  
379 take a look at this legislation and maybe bring it up for  
380 consideration.

381           Thankfully, Mr. Chairman, there is hope that we can  
382 avoid these additional cuts to Medicare Advantage. Over 200  
383 Members, as was mentioned in earlier opening statements, of  
384 both parties, including myself, sent a letter to the  
385 Administration opposing these proposed cuts. We must protect  
386 our seniors and their healthcare plans by opposing these  
387 cuts.

388           I sincerely appreciate the opportunity to testify and  
389 commend the committee for their work to protect seniors in  
390 Minnesota and around the country.

391           [The prepared statement of Mr. Paulsen follows:]

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392 \*\*\*\*\* INSERT A \*\*\*\*\*

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|

393           Mr. {Pitts.} The chair thanks the gentleman and now  
394 recognizes Mr. Denham, 5 minutes for an opening statement.

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|  
395 ^STATEMENT OF HON. JEFF DENHAM  
  
396 } Mr. {Denham.} This is straightforward legislation. It  
397 will serve to inform the more than 14 million seniors  
398 currently enrolled in Medicare Advantage about how the  
399 Affordable Care Act is affecting the healthcare plans that  
400 they rely on every day.  
  
401 For over 60,000 seniors who are enrolled in Medicare  
402 Advantage in the counties I represent, the Medicare  
403 Advantage program has been tremendously successful in  
404 improving health outcomes when compared to traditional  
405 Medicare fee-for-service. This is because the Medicare  
406 Advantage model emphasizes preventive services and managed  
407 care to keep beneficiaries healthy.  
  
408 Medicare Advantage plans also limit out-of-pocket costs,  
409 protecting vulnerable seniors from the threat of bankruptcy  
410 due to the complicated medical conditions. Maybe this is why  
411 a survey of Medicare Advantage beneficiaries found that 90  
412 percent were satisfied with their coverage, 92 percent were  
413 satisfied with their choice of doctor, and 94 percent were

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414 satisfied with the quality of care received under Medicare  
415 Advantage.

416         The 14 million seniors enrolled in Medicare Advantage  
417 plans nationwide deserve to know that the massive government  
418 overhaul of our healthcare system was paid for in part by the  
419 \$300 billion in cuts to Medicare Advantage plans and a health  
420 insurance tax that has just started this year.

421         The combined effects of these payment cuts and the new  
422 health insurance tax are already being felt through cancelled  
423 plans, reduced benefits and increased copays. During this  
424 year alone, beneficiaries in over 2,000 counties will have  
425 fewer plan options compared to 2013 and on average will see  
426 their annual costs increased by nearly 10 percent.  
427 Unfortunately, the impact will only grow with time.

428         As an example, in 2015, seniors in Stanislaus County in  
429 my district can expect to pay an additional \$90 per month, or  
430 \$1,080 per year for their Medicare Advantage plan. A large  
431 percentage of the 33,000 enrollees in Stanislaus County are  
432 low-income individuals earning under \$20,000 per year. This  
433 rate increase will force them out of participating in the  
434 Medicare Advantage program altogether. Did the 111th

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435 Congress really mean to cut Medicare Advantage in order to  
436 subsidize the Affordable Care Act? Whether Congress meant to  
437 or not, seniors have a right to know that these changes are  
438 coming so that they can actually plan and budget for these  
439 increases that they are going to see.

440 Mr. Chairman, as you are well aware, there have been at  
441 least 37 major alterations to the Affordable Care Act since  
442 it was enacted. Some of these were done in cooperation with  
443 the Congress, yet on 20 separate occasions, after it became  
444 clear that the implementation of the law was failing the  
445 American people, the Administration moved unilaterally to  
446 change the law. These delays and alterations are proof that  
447 the Affordable Care Act is not working as intended.  
448 Unfortunately for our seniors in our districts, while the  
449 promises of healthcare remain unfulfilled, the cuts and taxes  
450 on Medicare Advantage plans required to finance the law are  
451 moving forward as scheduled.

452 Congress must act today to protect the future of  
453 Medicare Advantage by repealing the cuts and taxes on the  
454 program. This would prevent the immediate erosion of health  
455 security for Medicare Advantage beneficiaries while we work

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456 to replace the Affordable Care Act with a healthcare reform  
457 that puts patients and seniors first.

458           Until we can enact such legislation, seniors have the  
459 right to know why their Medicare Advantage plans are being  
460 impacted and I urge this committee to support this bill.

461           I would also like to thank the 60 Plus Association and  
462 the Association of Mature American Citizens for their support  
463 of this legislation and would like to submit their letters  
464 for the record.

465           [The prepared statement of Mr. Denham follows:]

466 \*\*\*\*\* INSERT B \*\*\*\*\*

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|

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

468 The chair thanks the gentleman and now recognizes the

469 gentleman from Florida, Mr. Ross, 5 minutes for an opening

470 statement.

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|

471 ^STATEMENT OF HON. DENNIS A. ROSS

472 } Mr. {Ross.} Thank you, Chairman Pitts and Ranking  
473 Member Pallone, committee, for taking the time today to hold  
474 this hearing to highlight the significant threat facing the  
475 Medicare Advantage program.

476 In 2012, healthcare spending in the United States  
477 accounted for 17.2 percent of our Nation's economic output,  
478 equal to \$8,915 per person. Mr. Chairman, these statistics  
479 tell me that for a country with arguably the best healthcare  
480 in the world, we have yet to properly align patient and  
481 provider incentives to enable our healthcare system to be  
482 cost-efficient, highly accessible, and ultimately to achieve  
483 self-sustaining cost-containment with little need for  
484 government intervention.

485 More than 3.5 million Medicare beneficiaries reside in  
486 my home State of Florida; 1.2 million of these beneficiaries  
487 have chosen a Medicare Advantage plan over Medicare's  
488 traditional and more costly fee-for-service structure. In  
489 fact, since 2008, the State of Florida alone has seen a 30

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490 percent increase in the number of Medicare Advantage plan  
491 beneficiaries, while currently, 30 percent of our Nation's  
492 Medicare population have opted for a Medicare Advantage plan,  
493 serving as a clear testament to the high level of patient  
494 satisfaction the program has achieved.

495         Among the many satisfied Medicare Advantage plan  
496 beneficiaries in the State of Florida are Michael and Sandra  
497 Cox from my hometown of Lakeland, Florida. Michael and  
498 Sandra did what so many Medicare Advantage plan beneficiaries  
499 have done since January 1, 2014, writing to their Members of  
500 Congress expressing a mix of anger, confusion, and panic at  
501 the senseless cuts that have been made to this effective  
502 program. Sandra and Michael wrote, ``Please explain the  
503 logic of the ObamaCare cuts to Medicare Advantage. My  
504 husband and I have never experienced such a high level of  
505 satisfaction with our health coverage as we have with our  
506 Medicare Advantage plan, and all with a much cheaper monthly  
507 Premium.''

508         Unfortunately, Michael and Sandra learned on January 1  
509 that the doctors that they had been seeing for more than 10  
510 years were no longer available under the Medicare Advantage

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511 plan as a result of the continued cuts to the program. They  
512 would face the full out-of-pocket cost should they choose to  
513 continue seeing those providers they had come to know over  
514 the last 10 years and their health status they treated so  
515 well.

516 Mr. Chairman, was it not the Administration's goal to  
517 ensure patients develop a relationship with their provider  
518 resulting in better prevention and a more consistent  
519 continuum of care?

520 Unfortunately, these cuts to Medicare Advantage, like so  
521 many other healthcare-related actions by this Administration  
522 are contradictory to the purported message. Even more  
523 baffling, past cuts have already crippled innovative programs  
524 like home health visits instituted by Medicare Advantage plan  
525 sponsors to ensure our seniors are able to maximize the value  
526 of healthcare services they receive. Going forward,  
527 additional cuts of this magnitude will devastate medical  
528 innovation in areas like tele-health that show great promise  
529 for increasing efficiency and cost-containment in Medicare  
530 Advantage and the healthcare system at large.

531 Overall healthcare spending and utilization habits are a

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532 critical threat to America's declining fiscal health. If we  
533 are to successfully curb healthcare costs, we must preserve  
534 and enhance the Medicare Advantage program because of its  
535 proven ability to achieve cost-efficiency while maximizing  
536 patient access to high-quality health services and providers.

537 To be more specific, data collected between 2003 and  
538 2009 showed service utilization rates in areas like emergency  
539 department use and ambulatory surgery were 20 to 30 percent  
540 lower among Medicare Advantage beneficiaries than traditional  
541 Medicare.

542 Overutilization of healthcare services, however, is only  
543 one facet of healthcare cost growth tempered by the Medicare  
544 Advantage plan structure. Although this current  
545 Administration has tried to discredit the power of market  
546 competition in creating organic, self-sustaining incentives  
547 for patients, providers, and insurers alike, the facts always  
548 prevail. Artificial market controls put in place by the  
549 Federal Government lead to more out-of-control health  
550 spending, as we have seen time and time and again.

551 As far back as 1995, health economists have shown that  
552 combining coverage like that offered by Medicare Advantage

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553 with appropriate patient incentives leads to an avoidance of  
554 excessive doctor visits and tests, as well as more engaged  
555 patients seeking the best value for the healthcare service  
556 they need.

557 In this same vein, I was proud to introduce H.R. 4180,  
558 the Preserving Health Savings Accounts for Medicare  
559 Beneficiaries Act, which would allow for this consistently  
560 proven economic strategy for reducing healthcare costs across  
561 the spectrum. My legislation would incentivize younger  
562 Americans to establish Health Savings Accounts with the  
563 promise that upon being Medicare-eligible, they are able to  
564 Transfer the HSA funds into a Medicare savings account.

565 Simple enhancements like this one will help both  
566 Medicare Advantage and the entire healthcare system achieve  
567 organic alignment between insurers and patients and providers  
568 and creating a powerful, self-sustaining cost-containment  
569 tool. Patients have more control over their healthcare  
570 dollars, increasing awareness of reasonable health service  
571 costs and quality options, while also actively engaging  
572 providers to offer the highest quality service at the lowest  
573 reasonable cost in order to earn a patient's business.

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574           Mr. Chairman, this is what value in healthcare looks  
575 like. Unfortunately, through continued cuts to the Medicare  
576 Advantage program, this Administration will eliminate any  
577 possibility we currently have to build upon the Medicare  
578 Advantage program's success in curbing healthcare cost.

579           And I yield back.

580           [The prepared statement of Mr. Ross follows:]

581           \*\*\*\*\* INSERT C \*\*\*\*\*

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|

582 Mr. {Pitts.} The chair thanks the gentleman.

583 And now the chair is proud to introduce from the State

584 of Pennsylvania Mr. Rothfus and recognize him for 5 minutes

585 for an opening statement.

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|

586 ^STATEMENT OF HON. KEITH J. ROTHFUS

587 } Mr. {Rothfus.} Chairman Pitts, Ranking Member Pallone,  
588 and Members of the Subcommittee, thank you for having me here  
589 today to testify about H.R. 2453, the Medicare Beneficiary  
590 Preservation of Choice Act. I am very pleased to discuss  
591 this bipartisan legislation that Congressman Kurt Schrader  
592 and I introduced in June of 2013.

593 Enacting H.R. 2453 is one small fix we can make to  
594 Medicare Advantage that can have a big impact on the lives of  
595 the seniors utilizing the program in our districts. It  
596 simply restores the open enrollment period that existed prior  
597 to 2011. This open enrollment period permitted seniors to  
598 change Medicare Advantage plans once between January and  
599 March if needed. It essentially let seniors test drive the  
600 Medicare Advantage plan they would have just selected and  
601 change plans if it turns out the plan is not working for  
602 them. H.R. 2453 is about choice and fairness for seniors.  
603 It is about empowering them to make decisions about their  
604 healthcare needs.

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605 Restoring the January to March open enrollment period  
606 also makes sense in light of the 2014 Medicare Advantage cuts  
607 and the new cuts just proposed by CMS. Last November, the  
608 Wall Street Journal reported that one of the Nation's largest  
609 Medicare Advantage providers had dropped thousands of doctors  
610 from network due to ``significant changes and pressures in  
611 the healthcare environment.''

612 This is significant because seniors may not have known  
613 about the change in time to adjust their decisions during the  
614 October to December enrollment period. So if they liked  
615 their doctor, seniors may be finding out just now that they  
616 cannot keep him or her because they are no longer included in  
617 the plan. Passing H.R. 2453 and restoring the 90-day open  
618 enrollment period during the first quarter of the year would  
619 let seniors react to these types of plan changes, many of  
620 which are driven by the harmful cuts to Medicare Advantage  
621 that we see happening as the result of the Affordable Care  
622 Act.

623 H.R. 2453 is a patient-centered option for improving  
624 Medicare Advantage. It will provide choice for seniors and  
625 it will ensure that they have access to the doctors they know

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626 and trust. That is why it is supported by America's Health  
627 Insurance Plans, the Association of Mature American Citizens,  
628 and the 60 Plus Association.

629 The subcommittee members and its chairman should be  
630 thanked for their efforts to strengthen Medicare Advantage.  
631 Medicare Advantage delivers quality healthcare and peace of  
632 mind with consistently superlative satisfaction ratings from  
633 participants. Preserving the program and preventing more  
634 cuts to Medicare Advantage is a top priority for me and for  
635 the seniors in Pennsylvania's 12th District. Incidentally,  
636 in my district, utilization of Medicare Advantage is in  
637 excess of 60 percent, more than double the national rate.

638 Additional cuts to Medicare Advantage will lead to  
639 higher out-of-pocket costs, reduced benefits, and fewer plan  
640 options. Instead of limiting access to a successful program  
641 which 9 out of 10 seniors are satisfied with, we should be  
642 empowering them to make choices about what best suits them.  
643 We should make sure seniors have access to the healthcare  
644 providers they know and trust. Instead of cutting Medicare  
645 Advantage, we should be finding solutions to lower costs for  
646 seniors and sustain the program for the long run.

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647 I had an incident this past Monday with a senior in my  
648 district at a restaurant. She was the hostess and she  
649 expressed to me a real concern about the cuts to Medicare  
650 Advantage personally impacting her. I asked her to call my  
651 office and give us more background because I wanted to tell  
652 that story here in Washington. And she simply looked at me  
653 and said why? So the politicians can accuse me of lying?  
654 That is what is happening out there in the country. People  
655 are very concerned about what is happening with Medicare  
656 Advantage.

657 I thank the chairman and I yield back.

658 [The prepared statement of Mr. Rothfus follows:]

659 \*\*\*\*\* INSERT D \*\*\*\*\*

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|

660           Mr. {Pitts.} The chair thanks the gentleman and now  
661 introduces the gentlelady from Indiana, Ms. Walorski. I  
662 recognize her for 5 minutes for an opening statement.

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|

663 ^STATEMENT OF HON. JACKIE WALORSKI

664 } Ms. {Walorski.} Thank you, Mr. Chairman. Chairman  
665 Pitts, Ranking Member Pallone, members of the subcommittee,  
666 it is an honor to be here today and I thank you for holding  
667 this hearing to examine Medicare Advantage, a vital program  
668 that is critical to the health and well-being of many of our  
669 nation's seniors.

670 Over 15 million Americans depend on Medicare Advantage.  
671 Through this popular program, seniors and individuals with  
672 disabilities are able to select a private health plan of  
673 their choice that provides affordable, comprehensive  
674 coverage, disease management, and care coordination.

675 The Affordable Care Act and other regulatory changes  
676 have placed significant financial strain on this program, the  
677 brunt of which will be borne by the seniors we have promised  
678 to protect. Cuts to Medicare Advantage mean higher out-of-  
679 pocket costs, a more limited choice of doctors, decreased  
680 management of chronic conditions, and decreased coverage for  
681 dental and vision services.

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682           In my home State of Indiana, 22 percent of Medicare-  
683 eligible Hoosiers have chosen to enroll in Medicare  
684 Advantage, and enrollment in my district is even as high as  
685 27 percent. This program serves my constituents well, and I  
686 am deeply concerned about how cuts will impact seniors in the  
687 Hoosier State.

688           Marcia from Mishawaka told me she is very pleased with  
689 her Medicare Advantage program. She loves the quality of the  
690 services provided and the prescription drug program that is  
691 included. She is worried about the looming cuts because she  
692 wants to keep her current doctor. As a senior citizen living  
693 on a fixed income, it is important that her premiums remain  
694 low and she wonders who will take care of seniors if the cuts  
695 continue.

696           Eighty-seven-year-old Phyllis and her 93-year-old  
697 husband Owen like the peace of mind that comes with knowing  
698 they will receive excellent care through their current  
699 healthcare plan. Back in June, Phyllis fell and broke her  
700 hip. She was promptly picked up by an ambulance, admitted to  
701 surgery, and received excellent follow-up care in rehab. Her  
702 Medicare Advantage plan took care of the costs. Owen had a

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703 pacemaker inserted last year, which was also taken care of by  
704 his MA plan. Originally, there was no premium for this plan.  
705 Now they pay \$34 a month. Although \$34 a month may not seem  
706 like much, Phyllis told me if their premiums become too high,  
707 they will have to cut back on other necessities. Phyllis and  
708 Owen never imagined the Affordable Care Act would negatively  
709 impact them, especially when the President said that you can  
710 keep your healthcare plan if you like it. But now their  
711 healthcare plan is in jeopardy, too.

712 Medicare Advantage plans are particularly critical to  
713 low-income and minority beneficiaries. According to a study  
714 by America's Health Insurance Plans, 1 of 5 of those enrolled  
715 in Medicare Advantage are minorities and 41 percent of  
716 enrollees have annual incomes of less than \$20,000. Cuts to  
717 the program have the potential to disproportionately affect  
718 these most vulnerable populations.

719 That is why I introduced H.R. 4211, the Advantage of  
720 Medicare Advantage for Minorities and Low-Income Seniors Act  
721 of 2014. This legislation directs the Government  
722 Accountability Office to study the number of minority and  
723 low-income seniors enrolled in Medicare Advantage and to

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724 assess the impacts of Medicare Advantage payment reductions  
725 resulting from the Affordable Care Act and other  
726 administrative actions.

727         Studies show that enrollees in Medicare Advantage have  
728 lower hospital readmissions, receive higher quality of care,  
729 and enjoy better health outcomes as compared to their  
730 counterparts in traditional fee-for-service Medicare.  
731 Medicare Advantage serves as a vital source of coverage for  
732 low-income and minority beneficiaries.

733         On behalf of my constituents in the 2nd District and all  
734 Hoosiers, I look forward to working with both Congress and  
735 the Administration to keep the promise to maintain the  
736 integrity of Medicare Advantage. Thank you for the  
737 opportunity to appear before you this morning.

738         [The prepared statement of Ms. Walorski follows:]

739 \*\*\*\*\* INSERT E \*\*\*\*\*

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|  
740           Mr. {Pitts.} The chair thanks the gentlelady and again  
741 thanks the Members for the testimony on your initiatives. We  
742 will be happy to work with you on those. Thank you for  
743 taking time out of your busy schedules to appear before us  
744 today.

745           There will be no questions. I will excuse panel one at  
746 this time and call the second panel to the table and  
747 introduce them in the order that they will make  
748 presentations.

749           First, Mr. Frank Little, a Medicare beneficiary with a  
750 Medicare Advantage plan; secondly, Dr. Mitchell Lew, CEO and  
751 Chief Medical Officer of Prospect Medical Systems; thirdly,  
752 Mr. Glenn Giese, Principal, Oliver Wyman Consulting  
753 Actuaries; and then Ms. Judith Stein, Executive Director,  
754 Center for Medicare Advocacy; and finally, Dr. Paul Van de  
755 Water, Senior Fellow, Center on Budget and Policy Priorities.

756           Thank you all for coming today. Your written testimony  
757 will be made part of the record, and we will give each of you  
758 5 minutes to summarize your testimony.

759           Mr. Little, we will start with you. You are recognized

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760 for 5 minutes.

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|

761 ^STATEMENTS OF FRANK LITTLE, MEDICARE BENEFICIARY WITH A  
762 MEDICARE ADVANTAGE PLAN; MITCHELL LEW, M.D., CEO AND CHIEF  
763 MEDICAL OFFICER, PROSPECT MEDICAL SYSTEM; GLENN GIESE,  
764 PRINCIPAL, OLIVER WYMAN CONSULTING ACTUARIES; JUDITH STEIN,  
765 EXECUTIVE DIRECTOR, CENTER FOR MEDICARE ADVOCACY; AND PAUL N.  
766 VAN DE WATER, SENIOR FELLOW, CENTER ON BUDGET AND POLICY  
767 PRIORITIES

|

768 ^STATEMENT OF FRANK LITTLE

769 } Mr. {Little.} Chairman Pitts and members of the  
770 committee, thank you for providing me this opportunity to  
771 testify about my personal experience with the Medicare  
772 Advantage plan.

773 My name is Frank Little. I am a retired small business  
774 owner from Virginia Beach. I am 70 years old. My wife and I  
775 have been enrolled in three different Medicare Advantage  
776 plans over the past 5 years. We have received high quality,  
777 affordable coverage through our Medicare Advantage plans, but  
778 we are concerned that our plan choices are shrinking due to

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779 the deep funding cuts in this program.

780           When I first became eligible for Medicare, I had a  
781 choice of four different Medicare Advantage plans that  
782 offered prescription drug benefits with no additional  
783 premiums. Over the years, uncertainty about the program  
784 funding has forced several of these plans to either withdraw  
785 from my area or increase premiums.

786           Today, I am enrolled in a Medicare Advantage plan  
787 offered by Humana, which is still the only plan in my area  
788 offering a plan that includes prescription drug coverage with  
789 no additional premium. I am very satisfied with my Medicare  
790 Advantage plan and feel fortunate to have this option.

791           To help the committee understand why my Medicare  
792 Advantage plan is important to me, I want to explain my  
793 experience over the last several years. I have had three  
794 major medical problems since I retired. I have had open-  
795 heart surgery, colon cancer, and a medical procedure on my  
796 lungs. I estimate that my medical bills for these conditions  
797 have totaled approximately \$750,000 over the last 5 years,  
798 and I am pleased to tell you that my Medicare Advantage plans  
799 have covered almost all of these expenses. I have paid only

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800 a few hundred dollars in out-of-pocket costs. Without my  
801 Medicare Advantage plan, I would have faced a high deductible  
802 and 20 percent copayments if I had not been enrolled in the  
803 original Medicare program.

804 Like many seniors, I live on a fixed income and such  
805 high costs would have had a devastating impact on my budget.  
806 I also want to emphasize that my Medicare Advantage plan has  
807 allowed me to receive high quality care from my personal  
808 physician, from outstanding specialists, and from an  
809 excellent hospital in my community.

810 Other seniors in my community have several stories to  
811 tell about the quality coverage they receive through their  
812 Medicare Advantage plan. We appreciate that our plan  
813 provides prescription drug coverage as part of our medical  
814 coverage, while also taking care of our expenses to ensure  
815 that our out-of-pocket expenses are affordable.

816 My message to Congress is that I want you to make sure  
817 that Medicare Advantage continues to be a strong and  
818 adequately funded program. I am asking you to block any  
819 additional funding cuts. I am counting on both Congress and  
820 the Obama Administration to do the right thing and protect

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821 this program from any further funding cuts.

822 In closing, I want to say that I love my Medicare

823 Advantage plan and I will be deeply disappointed if I lose my

824 plan. Thank you for considering my comments on this

825 important issue.

826 [The prepared statement of Mr. Little follows:]

827 \*\*\*\*\* INSERT F \*\*\*\*\*

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|

828           Mr. {Pitts.}   The Chair thanks the gentleman.   I now

829   recognize Dr. Lew 5 minutes for an opening statement.

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830 ^STATEMENT OF MITCHELL LEW, M.D.

831 } Dr. {Lew.} Thank you, Chairman Pitts, Ranking Member  
832 Pallone, and members of this committee for the invitation to  
833 testify today. My name is Dr. Mitchell Lew, and I am part of  
834 the CAPG National Board and am pleased to testify on behalf  
835 of CAPG, which is the largest association in the country of  
836 physician organizations that practice capitated coordinated  
837 care.

838 CAPG members represent 160 medical groups in 20 States  
839 and serve 1.2 million Medicare Advantage enrollees. I also  
840 address you as a physician who practiced for 10 years before  
841 transitioning to a physician executive role 15 years ago. I  
842 am CEO of Prospect Medical Group, which is an IPA model with  
843 over 4,500 physicians in three States and serving 225,000  
844 members. This model allows us to contract with smaller  
845 physician practices under the umbrella of one large  
846 organization.

847 For background, Prospect Medical began in 1985 and we  
848 have evolved over the years and we now offer a full range of

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849 coordinating care services and programs, and this has  
850 resulted in better value to our seniors. It is better care,  
851 better health with cost control. Prospect has grown and we  
852 now have physicians and hospitals in California, Texas, and  
853 Rhode Island.

854 I come to emphasize the merits of Medicare Advantage and  
855 the coordinated care model and the need to preserve the  
856 financial support for Medicare Advantage and to continue our  
857 investment into the model. Medicare Advantage takes a  
858 population-based payment approach, which reduces the high  
859 utilization incentives of traditional Medicare. It is value  
860 over volume. It is team-based. Physician organizations are  
861 structured to provide the best care at the right time in the  
862 most appropriate setting. Seniors are managed across an  
863 entire continuum of care. They get preventive services, home  
864 visits, high-intensity case management for the sickest  
865 members, chronic disease management, palliative care. It  
866 allows for innovation. Physicians are held to performance  
867 standards and they receive quality incentive payments.  
868 Social and behavioral services are also delivered in a  
869 coordinated manner.

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870           The impact of Medicare Advantage is better care, lower  
871 admissions, lower readmissions, lower lengths of stay, better  
872 outcomes, higher member satisfaction, more benefits, and  
873 higher interest among the new seniors. And that is  
874 particularly important for the low-income seniors who like  
875 the enhanced benefits and they need the enhanced benefits.  
876 Medicare Advantage has grown by 30 percent over the last 3  
877 years and now 50 percent of new Medicare enrollees are  
878 choosing Medicare Advantage.

879           The proposed reductions and cumulative cuts pose very  
880 serious threats. It will cause an erosion of the  
881 coordinating care infrastructure, higher cost-sharing, which  
882 will have a profound impact on the lower-income and minority  
883 seniors, fewer benefits. These cuts will undermine all of  
884 the progress that we have made in developing the healthcare  
885 delivery system.

886           Medicare Advantage should be the infrastructure that all  
887 of the newer models in fee-for-service should use to build  
888 coordinating care such as the ACOs and the medical homes. I  
889 urge Congress and the Administration to find ways that will  
890 strengthen not cut Medicare Advantage, develop policies that

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891 will promote population-based payments.

892 Medicare Advantage should be the foundation upon which  
893 the entire healthcare delivery system builds coordinating  
894 care. As you develop Medicare and fiscal policy, ask that  
895 you consider all that Medicare Advantage has to offer and  
896 know that additional cuts will have very serious consequences  
897 on the coordinated care model and the seniors that it serves.  
898 Without Medicare Advantage, we have very little chance to  
899 transform our healthcare delivery system.

900 Thank you very much, Mr. Chairman, and I look forward to  
901 your questions.

902 [The prepared statement of Dr. Lew follows:]

903 \*\*\*\*\* INSERT G \*\*\*\*\*

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|

904           Mr. {Pitts.} The chair thanks the gentleman and now  
905 recognizes Mr. Giese 5 minutes for an opening statement.

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|

906 ^STATEMENT OF GLENN GIESE

907 } Mr. {Giese.} Chairman Pitts, Ranking Member Pallone,  
908 and members of the subcommittee, thank you for the  
909 opportunity to testify. I am Glenn Giese, a senior principal  
910 with Oliver Wyman Actuarial Consulting. My testimony today  
911 will focus on the findings of a recent analysis by Oliver  
912 Wyman commissioned by America's Health Insurance Plans, which  
913 estimates the potential impact of funding cuts that would be  
914 imposed by Medicare Advantage program by proposed changes to  
915 the MA payment methodology in 2015.

916 Our analysis focused on the combined impact of  
917 preliminary payment policies and regulatory changes announced  
918 by CMS on February 21, 2014, in its 45-day notice and draft  
919 call letter, cuts included in the Affordable Care Act and  
920 other legislative provisions addressing MA payments.

921 Specifically, we identified nine different factors that  
922 would impact MA payments in 2015, most of which would reduce  
923 payments. A detailed explanation of these factors is  
924 outlined in the appendix to my testimony. We have calculated

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925 that the projected overall impact of these policies would be  
926 to reduce MA payments by an estimated 5.9 percent in 2015.  
927 We note that the impact of these changes on individual plans  
928 will vary based on a number of factors, including the  
929 geographic area in which the MA organization participates.

930 We further estimate that the 5.9 percent funding cut  
931 translates into a potential reduction of \$35 to \$75 per month  
932 or \$420 to \$900 for the year in funding that will be  
933 available to support the benefits of MA enrollees in 2015.  
934 These cuts, if implemented, would represent a second  
935 consecutive year of deep cuts in MA funding. Due to a  
936 combination of legislative and regulatory policies  
937 implemented for 2014, MA payments already have been cut by 4  
938 to 6 percent this year, resulting in cost increases and  
939 benefit cuts of \$30 to \$70 per month for beneficiaries. If  
940 the new changes proposed by CMS are implemented, the program  
941 would be hit by a double-digit cut over just a 2-year period,  
942 causing cost increases and benefit reductions that could  
943 total as much as \$1,740 per enrollee over 2 years according  
944 to our projections.

945 MA cuts proposed for 2015 could have far-reaching

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946 implications for over 15 million seniors and individuals with  
947 disabilities who are enrolled in MA plans. In our report we  
948 explained that these cuts ``could result in a high degree of  
949 disruption in the MA market,' ' including the potential for  
950 plan exits, reductions in service areas, reduced benefits,  
951 provider networks changes, and disenrollment from MA plans.

952 We further cautioned that the proposed funding cuts  
953 would disproportionately affect beneficiaries with low  
954 incomes, including the 41 percent of MA enrollees who have  
955 annual incomes below \$20,000. For these beneficiaries, the  
956 potential increase in out-of-pocket costs resulting from cuts  
957 would constitute a significant burden.

958 Another serious concern we highlight is that individuals  
959 who utilize healthcare services the most would adversely be  
960 affected if they lose their MA plans and are forced to move  
961 back through the Medicare fee-for-service program with its  
962 higher cost-sharing and lack of coordinating care. This is a  
963 particular concern for enrollees in Special Needs Plans that  
964 serve beneficiaries who have severe or disabling chronic  
965 conditions or who reside in institutions.

966 For example, Chronic Care SNPs offer services that are

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967 tailored to meet the specific medical needs of patients with  
968 diabetes, cardiovascular disease, and other conditions. The  
969 loss of these specialized services would be a serious blow to  
970 beneficiaries whose medical conditions require customized  
971 treatments and care.

972 Thank you again for the opportunity to testify and I  
973 encourage the subcommittee and Congress to consider the  
974 findings of our analysis as you communicate with CMS about  
975 its proposed payment policies and regulatory changes to the  
976 MA program for 2015.

977 [The prepared statement of Mr. Giese follows:]

978 \*\*\*\*\* INSERT H \*\*\*\*\*

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|

979           Mr. {Pitts.} The chair thanks the gentleman and now  
980 recognizes Ms. Stein 5 minutes for an opening statement.

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|

981 ^STATEMENT OF JUDITH STEIN

982 } Ms. {Stein.} Mr. Chairman Pitts, Ranking Member  
983 Pallone, and distinguished members of the subcommittee, thank  
984 you for inviting me to testify. I am Judith Stein, founder  
985 and Executive Director of the Center for Medicare Advocacy.  
986 I have dedicated my legal career to representing Medicare  
987 beneficiaries exclusively since 1977. The Center is a  
988 private, nonprofit organization based in Connecticut and  
989 Washington, D.C., with offices throughout the country. We  
990 responded to over 7,000 calls and emails from Medicare  
991 beneficiaries and their families each year.

992 Medicare beneficiaries have had the option to enroll in  
993 private health plans since the '70s. The Medicare private  
994 plan option, now called Medicare Advantage, prior Medicare  
995 Plus Choice, was supposed to provide equal or better coverage  
996 for beneficiaries at a lower cost than traditional Medicare.  
997 Unfortunately, that is not been the case. As you know, in  
998 fact on average, private MA plans, Medicare Advantage, are  
999 paid significantly more than it would cost to provide similar

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1000 coverage in traditional Medicare.

1001 Now, we recognize that MA plans can be a viable option  
1002 for some enrollees, but I must remind the committee that the  
1003 vast majority, 36 million or more older and disabled people,  
1004 are enrolled in traditional Medicare, which is no longer a  
1005 fee-for-service program, and 50 percent of all Medicare  
1006 beneficiaries have incomes under \$23,500 a year.

1007 At the Center, we regularly hear from families and  
1008 individuals who have had problems with their MA plans. One  
1009 of the most frequent issues we encounter concerning MA  
1010 coverage relates to post-acute care. For example, over the  
1011 last year the Center has received complaints from across the  
1012 country about MA plans that have denied coverage for skilled  
1013 nursing facility care despite the fact that the individuals  
1014 at issue were receiving nutrition through feeding tubes,  
1015 which under federal regulations and common sense is a skilled  
1016 service. We have heard this from Ohio, Pennsylvania,  
1017 Minnesota, and of course Connecticut.

1018 In fact, one of the beneficiaries who called us or the  
1019 family did was granted coverage on appeal but the MA plan  
1020 actually appealed that case to federal court. And we, a

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1021 nonprofit that is not paid by our clients, had to go to  
1022 federal court to make sure that that individual and the  
1023 others like him in that MA plan would get coverage and care.

1024         These issues are not new and occurred even at the height  
1025 of MA overpayments when plans were paid at an average of 114  
1026 percent of the amount traditional Medicare would spend on a  
1027 similar individual. In 2009, for example, the Center had to  
1028 take another case to federal court in order to obtain  
1029 coverage for an individual receiving tube feeding. But the  
1030 MA plan was so determined to deny coverage it continued that  
1031 case into federal court in Minnesota.

1032         One of the most important health considerations for  
1033 individuals is the ability to choose one's doctors and  
1034 healthcare providers. This is the choice that people really  
1035 care about. By design, as you know, MA plans contract with a  
1036 limited network of providers to care for enrollees. Some  
1037 coordinate care, but that is far from the normal course we  
1038 have found with their beneficiaries over the 30 plus years I  
1039 have done this work.

1040         For example, a Connecticut resident was referred to us  
1041 by his Congressman because he had almost \$100,000 in

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1042 outstanding medical bills for his recently deceased wife that  
1043 would have been covered had he been in traditional Medicare.  
1044 That is because he traveled to Florida to be with his  
1045 daughter where his wife fell. And while her fractured hip  
1046 was taken care of and paid for by the plan, it turned out she  
1047 had a brain tumor, and all the services related to the brain  
1048 tumor were not covered by the MA plan.

1049 Sometimes Medicare Advantage enrollees face barriers  
1050 close to home. When MA plans change their provider networks,  
1051 as they often do annually, enrollees often have to make sure  
1052 that their doctors will be in the plan in the coming year.  
1053 As you may know, the largest plan in our State of Connecticut  
1054 and in New York, Ohio, and Florida cut many, many providers,  
1055 2,250 doctors and healthcare facilities in Connecticut alone,  
1056 including Yale New Haven Hospital where my mother, who is on  
1057 traditional Medicare, recently had urgently needed  
1058 neurosurgery, which she would not be able to have if she was  
1059 in a Medicare Advantage plan. Neither physicians nor  
1060 Medicare patients in that plan, the largest in Connecticut--  
1061 and in Ohio, Florida, New York--were given adequate notice  
1062 regarding these extraordinary provider cuts.

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1063           In addition to the concerns raised for Medicare  
1064 beneficiaries by MA networks, too many plans fail to provide  
1065 adequate coverage and access to care when enrollees are  
1066 seriously ill. While I am grateful for the care that my co-  
1067 presenter has received from his MA plan, too often we find  
1068 that when people become truly ill or injured, they are less  
1069 satisfied with their MA plan. That has been the case with my  
1070 uncle just this year, my mother's brother, who is 92 and has  
1071 been in an MA plan all these years despite my protestations.  
1072 He is not receiving coordinating care or the care he needs.

1073           Mr. {Pitts.} Can you wrap up, please?

1074           Ms. {Stein.} Instead of focusing on how much Medicare  
1075 payments are being cut, which is not really a cut, Congress  
1076 should focus on making sure they provide what we are paying  
1077 for. It is simply unfair to ask beneficiaries and taxpayers  
1078 to shoulder extra payments to private plans that truly don't  
1079 provide uniformly better value. Enrollees in poor health  
1080 often receive less coverage and all have less options of  
1081 providers.

1082           Thank you.

1083           [The prepared statement of Ms. Stein follows:]

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1084 \*\*\*\*\* INSERT I \*\*\*\*\*

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|

1085           Mr. {Pitts.} The chair thanks the gentlelady and now  
1086 recognizes Dr. Van de Water 5 minutes for an opening  
1087 statement.

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|  
1088 ^STATEMENT OF PAUL N. VAN DE WATER

1089 } Mr. {Van de Water.} Mr. Chairman, Ranking Member  
1090 Pallone, and members of the subcommittee, I appreciate the  
1091 opportunity to be with you this morning. My statement  
1092 reviews the role of private health plans in Medicare,  
1093 identifies the factors that will hold down payments to  
1094 Medicare Advantage plans in 2015, and explains why the  
1095 Administration and Congress should reject demands from some  
1096 quarters to freeze Medicare Advantage payment rates in 2015  
1097 at their 2014 levels.

1098 For 40 years, Medicare beneficiaries have been able to  
1099 receive their benefits through private health plans. And as  
1100 you have heard, in 2014, 29 percent of beneficiaries are  
1101 enrolled in a private health plan through Medicare Advantage  
1102 and virtually all beneficiaries have access to such a private  
1103 plan. The remaining 70 percent or so of Medicare  
1104 beneficiaries are in traditional Medicare.

1105 Congress' advisory body, the Medicare Payment Advisory  
1106 Commission, has long recommended that Medicare's payment

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1107 system be neutral, favoring neither Medicare Advantage plans  
1108 nor traditional Medicare. But in recent years, the system  
1109 has been substantially tilted in favor of private plans, the  
1110 result of a large increase in MA payments enacted in the 2003  
1111 Medicare prescription drug law.

1112 In 2009, Medicare paid MA plans 14 percent more per  
1113 enrollee than what it would have cost traditional Medicare to  
1114 cover comparable enrollees. The Affordable Care Act is  
1115 gradually reducing MA payment rates to bring them more in  
1116 line with payments in traditional Medicare. This year in  
1117 2014, Medicare Advantage payment average only 6 percent  
1118 higher than the levels in traditional Medicare. These  
1119 overpayments, I must add, drive up premiums for beneficiaries  
1120 and weaken Medicare's finances.

1121 The Centers for Medicare and Medicaid Services has  
1122 recently announced preliminary 2015 payment policies for  
1123 Medicare Advantage plans. Although the health insurance  
1124 industry's trade association AHIP says that the CMS  
1125 announcement includes ``new proposed cuts,' ' the agency CMS  
1126 is simply applying current law.

1127 The announced payment policies reflect four factors that

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1128 will hold down MA payments in 2015. First, CMS continues to  
1129 phase in the payment reductions that health reform requires,  
1130 which curb some, but as I said, not all, of the excessive  
1131 payments to MA plans.

1132         Second, since MA payments are tied in part to the cost  
1133 per enrollee in traditional Medicare, the continuous slowdown  
1134 in fee-for-service spending lowers MA payment rates.

1135         Third, CMS is implementing more accurate risk adjustment  
1136 procedures as health reform requires. It will modestly  
1137 reduce MA payments to address the problem of up-coding.  
1138 Also, CMS will no longer include diagnoses identified during  
1139 a home assessment visit rather than a clinical encounter in  
1140 determining an enrollee's health status since these tend to  
1141 make enrollees appear sicker than comparable enrollees in  
1142 traditional Medicare.

1143         And fourth, ending a demonstration project that pays  
1144 higher-quality bonuses to some plans will effectively lower  
1145 payments in those plans in 2015 compared to 2014.

1146         Now, AHIP and other interest groups charge that the  
1147 preliminary 2015 payment policies will substantially increase  
1148 costs to MA participants and will reduce the choice of plans.

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1149 They ask that MA payment rates be frozen in 2015 at their  
1150 2014 levels, but I would argue that the Administration and  
1151 Congress should reject those demands.

1152 The predictions of doom and gloom are greatly  
1153 exaggerated. AHIP issued these same warnings about the MA  
1154 payment cuts that were made in 2014, but MA enrollment, as  
1155 you have noted, has nonetheless reached record levels. And  
1156 the Congressional Budget Office projects that MA plans will  
1157 continue to thrive despite further payment cuts. Nationwide,  
1158 the number of plans available dropped by only 3 percent in  
1159 2014, a small change that reflects both the offsetting  
1160 effects of newly entering plans and those departing the  
1161 market.

1162 Plans also responded to the payment reductions by  
1163 becoming more efficient. The unweighted average monthly  
1164 premiums for MA plans with prescription drug coverage  
1165 actually fell from 2013 to 2014 and is lower today than in  
1166 2011 or 2012. And again, this is also despite the payment  
1167 reductions.

1168 Wall Street certainly isn't pessimistic about Medicare  
1169 Advantage. In the wake of the CMS announcement, shares of

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1170 Humana, the second largest insurer in the MA market, recorded  
1171 their biggest single-day increase in 4 years and reached  
1172 their highest level in more than 30 years. Standard & Poor's  
1173 overall index for managed healthcare plans also climbed.

1174 Finally, preventing overpayments to Medicare Advantage  
1175 plans is sound policy. Along with the other cost-saving  
1176 provisions in the Affordable Care Act, eliminating  
1177 overpayments reduces premiums for all beneficiaries,  
1178 including the large majority who are not enrolled in MA plans  
1179 and extends the solvency of Medicare's Hospital Insurance  
1180 trust fund.

1181 Thank you, Mr. Chairman.

1182 [The prepared statement of Mr. Van de Water follows:]

1183 \*\*\*\*\* INSERT J \*\*\*\*\*

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|  
1184           Mr. {Pitts.} The chair thanks the gentleman. That  
1185 concludes the opening statements. We will begin questioning.  
1186 I will recognize myself for 5 minutes for that purpose.

1187           Mr. Little, I will go first to you. What would have  
1188 happened to you if you had had a health episode and were not  
1189 on an MA plan? How did your MA plan compare to what service  
1190 you might have received under traditional Medicare if you  
1191 could explain?

1192           Mr. {Little.} If I would have had traditional Medicare  
1193 with my problems that I had, instead of being approximately  
1194 \$400 out-of-pocket cost because I stayed 2 extra days at the  
1195 hospital when I had the open heart, if I had had traditional  
1196 Medicare, it would have cost me \$150,000 and it is a  
1197 financial burden.

1198           Mr. {Pitts.} Now, what would happen to you if you would  
1199 lose your MA plan that you have today?

1200           Mr. {Little.} Well, if I had looked at the closest  
1201 Medigap and it would add about \$700 to \$800 a year to my  
1202 cost, which, because I am retired, something would have to be  
1203 taken out of the budget to pay for the plan.

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1204           Mr. {Pitts.} All right. Well, according to the  
1205 Congressional Budget Office, the Affordable Care Act cut more  
1206 than \$300 million from the Medicare Advantage program to  
1207 spend on new government programs, new entitlement not for  
1208 seniors. What is your reaction to that?

1209           Mr. {Little.} Well, I have seen the cuts. When I  
1210 turned 65 5 years ago, we had four plans to choose from and  
1211 Medicare Advantage plans and I had always been with Blue  
1212 Cross Blue Shield so I signed up with them. I was informed  
1213 the following year that they were dropping that plan so I  
1214 went to Optima. They had the next-best plan. The following  
1215 May I got my letter that they were dropping me, and the third  
1216 year I went to Humana because they were basically the only  
1217 one left. And in my area that I live in, Virginia Beach,  
1218 Humana offers the only Medicare Advantage plan available.  
1219 The others said they had to drop it because of the higher  
1220 cost and cuts.

1221           Mr. {Pitts.} Can you describe what your plan has done  
1222 for you that you think may have prevented a hospitalization  
1223 or from returning to the hospital?

1224           Mr. {Little.} Yes, sir. Every January and June part of

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1225 the plan is to go into your GP and have a thorough checkup.  
1226 And of course I have to go to my cardiologist and have a  
1227 thorough checkup. But even the co-pay for those preventive  
1228 is zero for a GP and of course my specialist is \$35, which is  
1229 easily affordable. So they keep me running.

1230 Mr. {Pitts.} If you could do a ballpark, how much do  
1231 you think your health plan has saved you in costs out-of-  
1232 pocket, you know, costs for the services you need so far?

1233 Mr. {Little.} Well, I know in the last 5 years it has  
1234 saved me \$140, \$150,000.

1235 Mr. {Pitts.} Now, due to cuts in Medicare Advantage  
1236 under the Affordable Care Act, some seniors may get to keep  
1237 their plan at least this year but might still lose their  
1238 doctor or lose affordable premiums or lose needed benefits.  
1239 Have you lost your doctor or plan before?

1240 Mr. {Little.} No, sir.

1241 Mr. {Pitts.} Have you or your friends with Medicare  
1242 Advantage plans experienced fewer choices and higher cost?

1243 Mr. {Little.} We have experienced fewer choices but the  
1244 low cost is still there. And in fact, with all respect to  
1245 Ms. Stein, I don't know which Medicare Advantage plan they

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1246 have, but they need to switch.

1247 Mr. {Pitts.} All right. Let me go to Mr. Giese. What  
1248 are the tools that CMS has at its disposal to legally reduce  
1249 the impact of the cuts and the advance notice through  
1250 administrative or regulatory means?

1251 Mr. {Giese.} Some of the cuts are statutory and some of  
1252 the cuts are discretionary, so if Congress were to act,  
1253 things like the ACA productions, the demonstration plan, and  
1254 the risk score stuff could be changed. But the other stuff  
1255 that is discretionary is decided by CMS, so the rate book  
1256 change, which are the trends in Medicare Advantage, we are  
1257 not quite sure how CMS develops the trends. They are not  
1258 really released to the public. So that could change. That  
1259 is partially discretionary and I would say that is the  
1260 biggest one.

1261 Mr. {Pitts.} My time has expired unfortunately. The  
1262 chair recognizes the ranking member 5 minutes for questions.

1263 Mr. {Pallone.} Thank you, Mr. Chairman.

1264 I wanted to ask questions initially of Mr. Van de Water.  
1265 I have heard different views on whether the quality of care  
1266 that Medicare beneficiaries receive from an MA plan is any

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1267 different than fee-for-service Medicare. What is your take  
1268 on the relative quality of care provided in fee-for-service  
1269 versus MA plans?

1270 Mr. {Van de Water.} Mr. Pallone, I think the short  
1271 answer is that we don't really have clear data. I like to  
1272 rely on the Medicare Payment Advisory Commission. They are a  
1273 good impartial source. And in their report from last March  
1274 on Medicare payment policies, they said that according to  
1275 them we have little information on which to base a comparison  
1276 of MA quality indicators with those in private fee-for-  
1277 service.

1278 That having been said, the evidence is mixed. There are  
1279 some studies which some of the Members have referred to that  
1280 suggest that at least in some particular MA plans, quality  
1281 may be better. There is other data, for example, that MedPAC  
1282 sites that suggests that the quality is about the same on  
1283 average in Medicare Advantage plans and traditional Medicare.  
1284 So I think the right answer is that the record is probably  
1285 mixed that in some cases the quality is probably better but  
1286 we can't make that conclusion across the board.

1287 Mr. {Pallone.} Well, I think we should strive to

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1288 improve the quality provided to all Medicare beneficiaries  
1289 both in the fee-for-service system and the Medicare Advantage  
1290 program. Now, fee-for-service has undertaken new payment  
1291 models such as accountable care organizations, medical homes,  
1292 and other initiatives, and Congress, including our committee,  
1293 has made great bipartisan progress towards tying physician  
1294 Medicare payments more closely to the quality of care  
1295 provided. And now that MA plan payments are linked to  
1296 quality performance, the plans are also working to improve  
1297 quality. So what is your recommendation for steps we can  
1298 take to continue to improve quality for all Medicare  
1299 beneficiaries?

1300 Mr. {Van de Water.} Well, I think you are exactly right  
1301 to focus on the whole system. You know, we are developing--  
1302 this is referred to a mix of payment models. We have not  
1303 only traditional Medicare on the one hand and Medicare  
1304 Advantage plans, but we are developing intermediate models  
1305 such as accountable care organizations. I think that what  
1306 Congress has done to encourage these different payment models  
1307 is exactly the right thing. In your proposed SGR legislation  
1308 you have additional steps to develop models of that sort.

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1309 The quality bonuses in MA plans, that makes sense. So I  
1310 think in general you are on the right track.

1311 Mr. {Pallone.} All right. Let me ask you a question  
1312 about the mechanics of how Medicare Advantage plans are paid.  
1313 CMS reported that the proposed reductions will result in a  
1314 2.4 decrease to MA plan benchmarks in 2015 while the witness  
1315 from Oliver Wyman testified on their recent report and that  
1316 is a report that I remind everyone that the insurance  
1317 industry paid for, which claims that the plans' rates will be  
1318 cut by 5.9 percent. And the plans are saying these  
1319 reductions are going to either put them out of business,  
1320 force them to hike premiums, reduce benefits, or take other  
1321 drastic measures. On the other hand, they said this last  
1322 year, too, and yet nothing really happened. But I know this  
1323 is a very complex issue and I would like to get to the bottom  
1324 of it.

1325 So let's just talk about the facts. Can you please  
1326 explain the mechanics of how Medicare Advantage plans are  
1327 paid, like what a benchmark is, what a bid is, and how plans'  
1328 payments are determined?

1329 Mr. {Van de Water.} I will try to give a simple answer

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1330 which will necessarily be a bit oversimplified, but, as you  
1331 say, the key factors in determining when a plan gets paid  
1332 are, one, the plan's bid, which represents how much the plan  
1333 estimates that it will cost to provide Part A and Part B  
1334 services to a representative group of people, that is people  
1335 of sort of an average--

1336 Mr. {Pallone.} What I am trying to get at is whether  
1337 the reductions that CMS has proposed to the plan, you know,  
1338 whether the reductions are to the payments or the benchmarks?  
1339 And given the reductions in benchmarks, will the plans on  
1340 average end up getting less money than fee-for-service? But,  
1341 you know, go ahead.

1342 Mr. {Van de Water.} Okay. The answer is that the  
1343 reductions that are being discussed are the reduction to the  
1344 so-called benchmarks. What the plans actually get relates  
1345 both to the benchmarks and to what they bid and to other  
1346 factors, so there is a lot of intervening steps, and  
1347 reductions in the benchmarks don't translate one-for-one into  
1348 reductions in the plan payments.

1349 Mr. {Pallone.} So can we say that the proposed  
1350 reductions and benchmarks will on the average end up that the

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1351 plans get less money than fee-for-service Medicare?

1352 Mr. {Van de Water.} Other things being equal, they will  
1353 tend to reduce what the Medicare Advantage plans get paid,  
1354 but on average, in 2015 MA plans are still going to get paid,  
1355 more than what it would cost to cover their enrollees under  
1356 traditional Medicare.

1357 Mr. {Pallone.} All right. Thank you.

1358 Mr. {Pitts.} The chair thanks the gentleman and now  
1359 recognizes the vice chairman of the subcommittee, Dr.  
1360 Burgess, 5 minutes for questions.

1361 Dr. {Burgess.} Thank you, Mr. Chairman. I would like  
1362 to address this to Dr. Lew and Mr. Giese. I mean you heard  
1363 the ranking member's question to Dr. Van de Water about the  
1364 issue of quality between Medicare Advantage and traditional  
1365 Medicare. Can you offer us your perspectives on that? Is  
1366 there a difference in your estimation on the difference  
1367 between the quality of care provided the enrollee in  
1368 traditional Medicare versus Medicare Advantage? Dr. Lew,  
1369 let's start with you.

1370 Dr. {Lew.} Yes. Thank you for that question.

1371 Absolutely I can attest to that, that the quality of care

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1372 delivered in a coordinating care model is far superior to a  
1373 fragmented fee-for-service system because you have got the  
1374 whole continuum of care. Again, as I mentioned, the home  
1375 visits coordinated with inpatient, outpatient visits,  
1376 palliative care and disease management. It is a team  
1377 approach where you have got providers, nurses, pharmacists,  
1378 social workers taking care of patients across the continuum.

1379         There was a mention about home care. Home care  
1380 absolutely is an essential piece of this. You take out home  
1381 care; that leaves a gap in our system. You know, it is not  
1382 an up-coding situation. It is a situation where we do  
1383 actually recognize what could be admission drivers. We look  
1384 for areas where a patient, perhaps he would be at a fall  
1385 risk. So there is a lot of information gathered at a home  
1386 visit. But absolutely, quality measures, there is no  
1387 question. We can reduce bed days, we reduce lengths of stay,  
1388 we reduce costs, we get better outcomes and obviously patient  
1389 satisfaction, and that is why members are wanting to migrate  
1390 to Medicare Advantage.

1391         Dr. {Burgess.} Thank you.

1392         Mr. Giese?

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1393           Mr. {Giese.} Thank you. There are studies out there  
1394 that show that the quality and fee-for-service is lower than  
1395 in MA on average, in fact, a number of studies. But going  
1396 beyond that, think about your parents and if they are sick.  
1397 They want to be taken care of. These people who sign up for  
1398 Medicare Advantage plans are so happy that they are taken  
1399 care of. They are called by the plan to say, you know, did  
1400 you take your prescription? Did you get a checkup? And the  
1401 people love this. It is so important to these people who  
1402 signed up for these plans.

1403           Dr. {Burgess.} Have there been any efforts to  
1404 identify--you know, we talk on this committee a lot about  
1405 readmission rates for patients with certain diagnoses. Is  
1406 there any evidence to point to, say, the readmission rate for  
1407 someone who is hospitalized with congestive heart failure  
1408 that is partly controlled, that is hospitalized, gets toned  
1409 up, gets sent home? Do they do better or worse on Medicare  
1410 Advantage?

1411           Mr. {Giese.} Readmission rates are lower in Medicare  
1412 Advantage. There have been some studies that show that.

1413           Dr. {Burgess.} Well, let me ask you a question and then

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1414 because part of this is we overpay Medicare Advantage. But  
1415 you have just identified one of the larger cost drivers and  
1416 you say that is less with Medicare Advantage. So how can it  
1417 be? A program that costs more is actually costing less? It  
1418 is paradoxical, isn't it?

1419 Mr. {Giese.} Well, all of the--

1420 Dr. {Burgess.} It is a trick question, Mr. Giese. I am  
1421 sorry. I couldn't help myself. Dealing with the  
1422 Congressional Budget Office all the time--

1423 Mr. {Giese.} All of the so-called overpayments to  
1424 Medicare go directly to beneficiaries. The rules for bids  
1425 and the way the bids work, everything goes back to the  
1426 beneficiary.

1427 Dr. {Burgess.} And I thank you for that. I did just  
1428 want to point out we deal with the tyranny of the  
1429 Congressional Budget Office all the time and it is  
1430 bipartisan. Both sides of the dais feel the tyranny of the  
1431 Congressional Budget Office.

1432 Mr. Little, I just have to ask you a question.

1433 Mr. {Little.} Yes, sir.

1434 Dr. {Burgess.} Your written testimony you have provided

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1435 you said you were a small business owner?

1436 Mr. {Little.} Yes, sir.

1437 Dr. {Burgess.} So were you self-employed?

1438 Mr. {Little.} Yes, sir.

1439 Dr. {Burgess.} So being self-employed, you know of  
1440 course you paid your taxes, your payroll taxes?

1441 Mr. {Little.} Yes, sir.

1442 Dr. {Burgess.} And for Medicare Part A, what was the  
1443 payroll tax that you paid during most of your years?

1444 Mr. {Little.} Well, nobody in my organization was that  
1445 old at that time.

1446 Dr. {Burgess.} Well, but I mean as you worked, in your  
1447 working years you pay Social Security and Medicare--

1448 Mr. {Little.} Oh, yes.

1449 Dr. {Burgess.} --every paycheck, right?

1450 Mr. {Little.} Oh, yes, sir.

1451 Dr. {Burgess.} Do you remember what the percentage was  
1452 that you paid for Medicare?

1453 Mr. {Little.} The FICA was 6.2. The Medicare was--I  
1454 don't know.

1455 Dr. {Burgess.} 1.3, I have it on good authority. It is

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1456 said it is 1.3 so let's stipulate that that is correct. But  
1457 you were a small business owner so for yourself you paid both  
1458 the employer and the employee contribution, is that correct?

1459 Mr. {Little.} Yes, sir.

1460 Dr. {Burgess.} So you paid 2.6 percent of your earnings  
1461 throughout your lifetime. So let me just ask you. Do you  
1462 feel that what you are receiving now and Medicare is an  
1463 entitlement or is that something for which you have paid?

1464 Mr. {Little.} Oh, I think it is something I have  
1465 earned.

1466 Dr. {Burgess.} Yes, exactly. Exactly so. And I just  
1467 wanted to make that point. It is then incumbent upon us to  
1468 make sure you get the very best of what is available, and in  
1469 your case, it sounds like that would be Medicare Advantage.

1470 I have gone over time. I will yield back.

1471 Mr. {Pitts.} All right. The chair thanks the  
1472 gentleman. I now recognize the gentleman, Mr. Green, 5  
1473 minutes for questions.

1474 Mr. {Green.} Thank you, Mr. Chairman.

1475 CMS proposed to disallow the use of the home assessment  
1476 diagnoses unless the beneficiary received appropriate follow-

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1477 up care as a good policy. Mr. Van de Water, I understand  
1478 that plans were allowed to use beneficiary diagnosis  
1479 information obtained during home assessment visits to  
1480 increase their risk adjustment payment. Basically what  
1481 happened is that the plans were providing assessments for  
1482 beneficiaries finding that there were certain diagnoses and  
1483 using that information for increased payment.

1484 But this is important in that plans were not following  
1485 up and providing the services the patient required as a  
1486 result of that diagnosis. So the plans get more money and  
1487 the patient doesn't receive anything. This seems like it is  
1488 a scam on tax dollars. Just so we are clear, can you please  
1489 explain exactly what CMS has proposed?

1490 Mr. {Van de Water.} Yes, sir. I think you actually  
1491 provided a very good summary yourself. All I would add is  
1492 that what CMS is proposing to do is not an anyway suggesting  
1493 that these home assessment visits cannot be helpful or  
1494 useful, but as you say, it is important that if a home  
1495 assessment visit takes place and a condition is found, that  
1496 the appropriate follow-up is provided. CMS is not saying  
1497 that diagnoses identified during home visits are never going

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1498 to be considered but simply they do have to be recognized by  
1499 the subsequent encounter with a doctor or health professional  
1500 to make sure that the appropriate follow-up is indeed taking  
1501 place.

1502 Mr. {Green.} It seems like if they are getting paid for  
1503 that assessment of that illness, they should be actually  
1504 treating that patient--

1505 Mr. {Van de Water.} Exactly.

1506 Mr. {Green.} --instead of just building up their  
1507 payment.

1508 What is your take on this policy? Is it reasonable to  
1509 require a plan if they wish to receive higher payments with  
1510 identifying a diagnosis to require they provide that patient  
1511 with those services?

1512 Mr. {Van de Water.} I am not sure we need to make the  
1513 requirement but we certainly shouldn't allow plans to get the  
1514 higher payments for the diagnoses if they are not followed up  
1515 on.

1516 Mr. {Green.} In other words, that is a cost savings we  
1517 could do. But we hear about in Medicare is overpayment if  
1518 they are not receiving the services that they are actually

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1519 being paid for.

1520 Mr. {Van de Water.} Yes. That is precisely what CMS  
1521 has tried to do in the proposed policy.

1522 Mr. {Green.} Medicare Advantage overpayment often hurt  
1523 beneficiaries and Medicare in the long run. Ms. Stein, I  
1524 know that you have been a strong advocate for strengthening  
1525 Medicare and ensuring it remains secure in the long run.  
1526 That is why I have concerns about continuing to overpay  
1527 Medicare Advantage. First, Medicare Part B premiums are  
1528 based on program spending, so the extent Medicare is paying  
1529 too much, it drives the beneficiary premiums up, isn't that  
1530 right?

1531 Ms. {Stein.} That is exactly correct. The overpayments  
1532 to the Medicare Advantage program are a problem not only for  
1533 Medicare Advantage enrollees but for all Medicare  
1534 beneficiaries because their Part B premiums increase and of  
1535 course taxpayers pay more for Medicare as a whole.

1536 Mr. {Green.} We know that most beneficiaries have  
1537 modest incomes, fixed incomes. They don't have a lot of  
1538 disposable income to pay extra to manage care. How are  
1539 beneficiaries affected by unjustified overpayments to private

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1540 insurance companies while the minority who are enrolled in  
1541 plans might see some additional benefits but how the vast  
1542 majority of Medicare beneficiaries are affected? It seems  
1543 like if you are raising premiums for--and I will take a  
1544 number out of the air--70 percent of the folks in my  
1545 district, last numbers I saw, received regular Medicare,  
1546 about 30 percent do Medicare Advantage. So you raise the  
1547 premiums for 70 percent to provide some additional benefit to  
1548 the 30 percent.

1549 Ms. {Stein.} That is correct. And I have to even  
1550 question the additional benefits. I mean what were mentioned  
1551 were vision, which is usually some help with some eyeglasses,  
1552 not very much, and preventive services, which are now zero  
1553 based in Medicare as a result of the Affordable Care Act.  
1554 And I have not seen a great deal of actual coordination.  
1555 When there is true coordination, I applaud it, but very  
1556 often, we have as much siloing of care in Medicare Advantage  
1557 as we have in traditional Medicare. It is costing everybody  
1558 more, even the vast majority who don't choose Medicare  
1559 Advantage but stay in traditional Medicare.

1560 Mr. {Green.} Well, I only have a few seconds left and I

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1561 have heard some folks argue that we can't take away access  
1562 payments to plans and put them on parity with fee-for-service  
1563 because some beneficiaries are low-income, rely on these  
1564 plans for additional benefits. And they do. I know Medicare  
1565 Advantage offers other things, but the problem is plans can  
1566 change their benefits and cost-sharing from year to year.  
1567 Just because a low-income person has a plan that would reduce  
1568 cost-sharing today, that plan doesn't necessarily have to  
1569 offer that extra benefit over that year.

1570 Ms. {Stein.} That is right. The plans can change the  
1571 benefits from year to year so long as they are actuarially  
1572 equivalent to traditional Medicare.

1573 And I just want to say CMS did do a study in 2012 that  
1574 showed about low-income people, people with high-risk needs  
1575 and health issues disproportionately disenroll from Medicare  
1576 as they are dealing with those issues across the country.

1577 I have no skin in this game. My entire career is just  
1578 representing mostly low- and moderate-income Medicare  
1579 beneficiaries and protecting Medicare. That is all I care  
1580 about here and getting access to care. And I think the  
1581 Medicare Advantage plan is providing way too much money for

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1582 way too little uniform value and it is hurting the Medicare  
1583 program and most Medicare beneficiaries. I say that as an  
1584 advocate, as a cancer survivor, and as the daughter of a  
1585 woman who is just going through an extraordinary neurosurgery  
1586 that was available to her because she was in traditional  
1587 Medicare.

1588 I can't understand why it would cost Mr. Little \$100,000  
1589 and I hope he will call my office if we can ever help him.  
1590 We don't charge for our services.

1591 Mr. {Green.} Okay. Thank you, Mr. Chairman. I know I  
1592 am over my time but I thank all of our witnesses for being  
1593 here.

1594 Mr. {Pitts.} The chair thanks the gentleman and now  
1595 recognizes the gentlelady from North Carolina, Mrs. Ellmers,  
1596 5 minutes for questions.

1597 Mrs. {Ellmers.} Thank you, Mr. Chairman, and thank you  
1598 to our panel for being here today.

1599 I just want to start off by associating myself with some  
1600 of the comments, Dr. Lew, that you had made about how our  
1601 seniors enjoy their Medicare Advantage plans and why it is so  
1602 important that we work in Congress to protect them from these

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1603 large cuts that will negatively affect 476,000 North Carolina  
1604 seniors that I have the incredible honor to represent.

1605 I am very concerned about this issue because I do  
1606 believe it is a choice that our seniors are able to make. I  
1607 think that our seniors are in jeopardy when they cannot make  
1608 choices for themselves. Mr. Little has made a choice of what  
1609 it is that he would like to see for his coverage, and I don't  
1610 understand why we would consider jeopardizing that ability.  
1611 When something works for someone, they should keep it. Isn't  
1612 that what our President said? If you like your healthcare  
1613 plan, you should be able to keep it. And yet now we are  
1614 saying no, as a matter of fact, you can't.

1615 And, Dr. Lew, thank you for your comments about patients  
1616 in the home health setting. You know, our seniors want to  
1617 take care of themselves. Our seniors want to be able to be  
1618 independent. And if they are going to do a better job  
1619 recovering from surgery or sickness, illness at home, I think  
1620 that is where they need to be. And I think these are all the  
1621 things that are jeopardizing our system.

1622 And to the point that Dr. Burgess was making earlier  
1623 about savings in one part of Medicare only to spend more

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1624 money in another, if we are helping to keep seniors out of  
1625 the hospital or the inpatient setting, that is a dramatic  
1626 savings within Medicare. So it only makes common sense to me  
1627 that we would continue to advocate another program or  
1628 Medicare Advantage that would help seniors be able to do  
1629 that. You know, keeping people out of the hospital is the  
1630 best way we can keep people healthy and safe in this country.

1631         There again, Dr. Lew, as a physician, do you believe  
1632 seniors in rural areas--I have a large rural area in my  
1633 district. How do you feel about seniors in the rural  
1634 setting? How do you feel that they respond to the higher  
1635 premiums or potentially no Medicare Advantage offered? I  
1636 mean how will that affect them?

1637         Dr. {Lew.} Well, if Medicare Advantage plans pull out  
1638 of certain markets, that will certainly leave seniors very  
1639 vulnerable. You know, there are some parts of certain States  
1640 that we do business in where there are very few Medicare  
1641 Advantage plans. In fact, recently, one plan pulled out of  
1642 one of these States where we do business and that left one  
1643 dominant player, which is very vulnerable, because after that  
1644 one player pulls out, the seniors are going to be left

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1645 without physicians and without a network. But, you know,  
1646 hopefully that won't happen.

1647 And, you know, to your point about seniors liking choice  
1648 and having choice and having the better outcomes on the back  
1649 end, that is all a result of what we have built, this  
1650 coordinating care model and what I consider an investment,  
1651 not an overpayment, but an investment into this model that we  
1652 have shown has worked that we are threatening now to  
1653 jeopardize by cuts. That is what I am concerned about  
1654 because that is going to impact the physicians and the  
1655 seniors.

1656 Mrs. {Ellmers.} Absolutely. And, you know, there  
1657 again, to me it is a matter of common sense. I struggled  
1658 with the idea that the Obama Administration and that CMS  
1659 would choose to hit something that is working so well as  
1660 Medicare Advantage when we have numerous programs that don't  
1661 work at the federal level. As a fiscally responsible  
1662 individual representing my constituents, this is simply not  
1663 the place that we should go for savings. There are many  
1664 others.

1665 And again, Mr. Little, I just want to thank you on

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1666 behalf of my constituents, my seniors for coming forward and  
1667 sharing your stories and your experience with the healthcare  
1668 issues that you had to deal with, with heart disease and  
1669 cancer, because that is just so important. And your recovery  
1670 and your ability to recover on your own terms probably had a  
1671 lot to do with the Medicare Advantage plan that you chose.

1672 Mr. {Little.} Yes, it did. And one thing I would like  
1673 to interject that I didn't before, I have noticed it because  
1674 I have been with the Medicare Advantage plan for 5 years.  
1675 The costs are kept down mainly because of what they pay the  
1676 hospitals, the physicians.

1677 Mrs. {Ellmers.} Um-hum.

1678 Mr. {Little.} I have noticed my checkup this year was  
1679 \$300. My doctor--

1680 Mrs. {Ellmers.} Um-hum.

1681 Mr. {Little.} --got \$74. There it is.

1682 Mrs. {Ellmers.} Um-hum.

1683 Mr. {Little.} There is your savings. It is not costing  
1684 the government any extra money. They are negotiating, but of  
1685 course that is why--

1686 Mrs. {Ellmers.} That is right.

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1687 Mr. {Little.} --several of the Medicare Advantage plans  
1688 dropped out because they couldn't get down--

1689 Mrs. {Ellmers.} Um-hum.

1690 Mr. {Little.} --to that price.

1691 Mrs. {Ellmers.} Um-hum.

1692 Mr. {Little.} And also with every claim that I do, and  
1693 they send me what I did, they also send a letter if you see  
1694 any fraud or anything that was done that wasn't really done,  
1695 please let us know immediately. So they self-govern  
1696 themselves and I think that is how they are keeping the cost  
1697 down.

1698 Mrs. {Ellmers.} Well, thank you again for being such a  
1699 great advocate on this issue. We truly appreciate it and my  
1700 constituents thank you.

1701 Mr. {Little.} You are welcome.

1702 Mrs. {Ellmers.} Mr. Chairman, I would like to submit to  
1703 the record a letter that we sent to Ms. Tavenner from the  
1704 Doctors Caucus. Members of the Doctors Caucus put it  
1705 together; I would like to submit it for the record.

1706 Mr. {Pitts.} Without objection, so ordered.

1707 [The information follows:]

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1708 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
1709 Mrs. {Ellmers.} Thank you, sir, and I yield back the  
1710 remainder of my time.

1711 Mr. {Pitts.} The chair thanks the gentlelady and now  
1712 recognizes the gentlelady from Virgin Islands, Dr.  
1713 Christensen, 5 minutes for questions.

1714 Dr. {Christensen.} Thank you, Mr. Chairman.

1715 Ms. Stein, we have heard a lot today about Medicare  
1716 Advantage plan choices and how seniors need to have a lot of  
1717 choices of different plans, but like you, I believe that the  
1718 most important choice that a senior can have is a choice of a  
1719 doctor, the ability to access your physician or even a  
1720 hospital where you are familiar with the services and you  
1721 know you will get good care.

1722 You spoke about Connecticut where you are headquartered  
1723 and where there was a serious problem when Medicare Advantage  
1724 plans abruptly dropped providers from the network leaving  
1725 beneficiaries, who had selected a plan based on being able to  
1726 continue to see their doctors, in the lurch. To me, this  
1727 highlights a very serious problem with Medicare Advantage.  
1728 Plans make these choices to contract with a provider and that

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1729 is a result of really business decisions. This is part of  
1730 the downside of having private insurance companies whose main  
1731 goal it is to make a profit serving vulnerable seniors. What  
1732 recommendations might you have for how Congress and CMS could  
1733 better protect seniors that Medicare Advantage plans from  
1734 such disruption?

1735 Ms. {Stein.} Thank you. I appreciate this opportunity.

1736 I think that the choice that people want of whatever age  
1737 is the choice of who is going to take care of them and where  
1738 they are going to be taken care of. And traditional Medicare  
1739 is pretty much an open network. You can go around the  
1740 country. So, for example, my mother has just come from  
1741 western Connecticut to eastern Connecticut to be in a nursing  
1742 home near me. If she was in a Medicare Advantage plan in our  
1743 State, that wouldn't be possible.

1744 So you can go near family, you can choose pretty much  
1745 all the doctors that are providing care, not all but most,  
1746 and also, as I said, Yale New Haven Hospital is no longer in  
1747 the largest Medicare Advantage plan in our State and that is  
1748 certainly not because of quality of care and that is because  
1749 before these further level playing field of Medicare

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1750 Advantage to the costs of traditional Medicare.

1751           One of the things I think is that we should look at the  
1752 definition of an adequate network in Medicare Advantage plans  
1753 and make sure that the definition is truly going to meet the  
1754 needs of the people who enroll. We should look to providing  
1755 enrollees whose plans terminate contracts with their doctors,  
1756 that they must be given notice regardless of what the plan  
1757 thinks of the adequacy of the network after that doctor and  
1758 their hospital is terminated. If the physician or local  
1759 hospitals that this person is known to use have been  
1760 terminated from that plan, they should be given notice of  
1761 that before it is effective.

1762           We should ensure clear, meaningful differences between  
1763 the different Medicare Advantage plans that a given sponsor  
1764 is offering because it is very hard for people to know what  
1765 they are choosing very often. We should standardize benefits  
1766 within plans, as Congress intelligently did with Medicare  
1767 supplement, Medigap, plans many years ago. You can really  
1768 tell apples to apples and know what you are getting.

1769           I would say finally, perhaps most importantly, we should  
1770 make sure that there is a true even, level playing field in

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1771 benefits and payments to traditional Medicare and Medicare  
1772 Advantage. If we want people to truly have choice, besides  
1773 their doctors, between Medicare Advantage and traditional  
1774 Medicare, we should make sure that the benefits are available  
1775 in both. Now, because of the Affordable Care Act, we have  
1776 mostly zero cost preventive services in traditional Medicare.  
1777 We should have the same reimbursement structure for those who  
1778 provide care in traditional Medicare as in Medicare  
1779 Advantage.

1780 We should offer prescription drug coverage in  
1781 traditional Medicare because people often go to Medicare  
1782 Advantage now because it is the only one-stop shopping. It  
1783 is the place where it is simpler. You go there, you get your  
1784 prescriptions usually and your other services. So they feel  
1785 they don't have that choice.

1786 Also, it is called Medicare Advantage. People think  
1787 they have some advantage. They think they are getting  
1788 something on top of Medicare. There should be a level  
1789 playing field between the two operating choices, the two  
1790 models.

1791 Dr. {Christensen.} Well, thank you. And I think some

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1792 of those, especially the adequate network, could be  
1793 applicable. There is a very troubling situation happening in  
1794 Tennessee, Florida, and Texas in dental Medicaid managed care  
1795 where providers are being dropped, and I hope that maybe at  
1796 some point we can have a hearing on Medicaid managed care as  
1797 well.

1798 Thank you for your time.

1799 Ms. {Stein.} It has been a huge issue in our State and  
1800 we lost almost all our Medicare Plus Choice plans. And now,  
1801 before these reductions and overpayments are in effect,  
1802 United Healthcare dropped 2,250 physicians and hospitals and  
1803 other care providers in Connecticut. That was a provider for  
1804 1 for every 200 Medicare beneficiaries in our State. It has  
1805 been stunning. And I fear this is going to be used as an  
1806 argument for even higher payments to Medicare Advantage when,  
1807 if we could put that money into traditional Medicare, all 50  
1808 million Medicare beneficiaries would benefit and taxpayers  
1809 would pay less.

1810 Mr. {Pitts.} The chair thanks the gentlelady,  
1811 recognizes the gentleman from New Jersey, Mr. Lance, 5  
1812 minutes for questions.

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1813 Mr. {Lance.} Thank you very much, Mr. Chairman.

1814 I recently had a constituent contact me to inform me  
1815 that her Medicare Advantage plan had been canceled and her  
1816 new plan requires her to pay \$600 per month, which is \$50  
1817 more than her previous plan, with no indication that she will  
1818 maintain her current plan benefits or the doctor she likes.  
1819 It is my experience that this woman, my constituent, is not  
1820 alone. According to Oliver Wyman actuaries, New Jersey, the  
1821 State I represent, will be one of the States hardest hit by  
1822 these proposed cuts. Approximately 217,000 New Jerseyans are  
1823 enrolled in Medicare Advantage and they may see a reduction  
1824 in benefits.

1825 And, Mr. Little, thank you for being here with us today,  
1826 and I am hoping you can tell us a little more about your  
1827 experience with Medicare Advantage and I imagine it is  
1828 similar to the experience of those in the district I serve  
1829 who have reached out to me. Would you please explain, sir,  
1830 to the committee why you chose a Medicare Advantage plan over  
1831 traditional Medicare?

1832 Mr. {Little.} Well, I go to the gym.

1833 Mr. {Lance.} Yes. My wife tells me I should go more

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1834 often.

1835 Mr. {Little.} Well, you will find it is really a  
1836 convention of old people talking. We shoot the bull more  
1837 than we exercise to be exact. But when I first became of  
1838 age, 65--

1839 Mr. {Lance.} Yes, sir.

1840 Mr. {Little.} --all the men that were in the gym and  
1841 stuff say, well, make sure you look at the advantage plan;  
1842 that is what you want to go with.

1843 Mr. {Lance.} Yes, sir.

1844 Mr. {Little.} And so I Googled it and, of course, came  
1845 up with four plans that were available. All of them were  
1846 great. I took Blue Cross Blue Shield because I had been with  
1847 them all my life when I was in business in a regular plan.  
1848 Of course, they dropped it the following year due to  
1849 financial things. Then, I shifted to Optima and then they  
1850 dropped it the following year. So then I only had Humana  
1851 left. That is the only one left in my place. And they had  
1852 been great. Whatever my GP says, when he found the mitral  
1853 valve going bad in my heart, he immediately sent me next door  
1854 to the cardiologist, and at 6:00 a.m. the next morning they

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1855 had my heart laying on the table fixing it. And of course  
1856 Norfolk Heart is one of the top 10 in the Nation.

1857 There is never, ever in the last 5 years, between my  
1858 pulmonary and my other physicians, anything about not being  
1859 able to have the best service there is and the one of my  
1860 choice. And of course for the last 12 years since I retired  
1861 I have kept my same doctor.

1862 Mr. {Lance.} When you had your open-heart surgery, your  
1863 primary care doctor worked with your specialist to ensure  
1864 that you received the care you needed. Is that your  
1865 testimony?

1866 Mr. {Little.} Yes, sir. He called right then. He said  
1867 you need to go right now because he heard something. And I  
1868 went to the cardiologist, which happened to have his office  
1869 next door, and he picked up the phone and he said be at  
1870 Sentara Heart tomorrow morning at 6:00 a.m. So it was fairly  
1871 quick.

1872 Mr. {Lance.} Thank you. Under traditional Medicare  
1873 without a supplemental policy I think that some senior  
1874 citizens could face financial difficulty and perhaps even  
1875 worse than financial difficulty due to the unpredictable

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1876 cost-sharing from unexpected illnesses or hospitalization,  
1877 and that is certainly one of my concerns.

1878 Dr. Lew, in your testimony you described how Medicare  
1879 Advantage incentivizes value and coordinating care whereas  
1880 that is not always the case with the fee-for-service Medicare  
1881 program. Would you please elaborate on the importance of  
1882 coordinated care and what this means for our Nation's senior  
1883 citizens?

1884 Dr. {Lew.} Right. Coordinated care, essentially, is it  
1885 is a team--

1886 Mr. {Lance.} Yes.

1887 Dr. {Lew.} --not just physicians, the whole, you know,  
1888 team of pharmacists and social workers and case managers  
1889 working along a continuum of care. So it is not just when a  
1890 patient comes into a hospital. It is home, hospital, office.  
1891 It is throughout no matter what type of problem that they  
1892 have.

1893 You know, and the other thing I wanted to note is we are  
1894 not a health plan. We are a physician group.

1895 Mr. {Lance.} Yes, sir.

1896 Dr. {Lew.} And so we get 85 cents on the dollar that is

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1897 passed to us. So what might look like a level playing field  
1898 is not when it gets down to the physician level, and that is  
1899 what we are dealing with when we are trying to deliver these  
1900 extra services and provide the great care to the seniors.

1901 Mr. {Lance.} Thank you. I think the testimony has been  
1902 compelling and certainly I hope that Medicare Advantage can  
1903 continue. That is a certainly my perspective based on my  
1904 representation of New Jersey.

1905 Thank you, Mr. Chairman.

1906 Mr. {Pitts.} The chair thanks the gentleman. Okay. I  
1907 guess Mr. Guthrie is here. The chair recognizes Mr. Guthrie  
1908 5 minutes for questions.

1909 Mr. {Guthrie.} Thank you, Mr. Chairman. Let me move  
1910 over to the microphone so it will be picked up. Thank you,  
1911 Mr. Chairman. I have a question for Dr. Lew.

1912 Some people have suggested that insurance companies are  
1913 being overpaid for Medicare Advantage and rates should be cut  
1914 to fee-for-service levels for equity. What do you think the  
1915 impact would be for patients if it was cut to fee-for-service  
1916 levels?

1917 Dr. {Lew.} Well, I think that the investment that was

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1918 made has been made over the years to build this model, which  
1919 I think now we are seeing the results of and the seniors like  
1920 it and that is why they are migrating over. I think that was  
1921 a smart investment.

1922 Now that we are facing cuts, which are really starting  
1923 to roll in right now--just January of this year I see it  
1924 happening with our company--you know, it is going to impact  
1925 physician payments. It will impact programs and services  
1926 that we are able to provide to seniors. And as these cuts  
1927 continue throughout '14 and '15, I think that is just going  
1928 to get worse.

1929 Mr. {Guthrie.} And how long have you cared for seniors  
1930 with Medicare Advantage plans and what do you think they like  
1931 the most about being in Medicare--

1932 Dr. {Lew.} I am sorry. I didn't hear that first  
1933 question.

1934 Mr. {Guthrie.} How long have you cared for seniors in  
1935 Medicare Advantage plans and what do you think they like the  
1936 most about being in Medicare Advantage?

1937 Dr. {Lew.} Our company has been taken care of Medicare  
1938 Advantage patients for 20 years and, you know, what I think

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1939 the seniors like is, again, the coordinating care that it is  
1940 not just the primary care and the specialist and the case  
1941 manager or the touches with member services. They like that  
1942 comprehensive treatment. And obviously we had given more  
1943 benefits, too. I mean we provide transportation and a lot of  
1944 other extra services.

1945 Mr. {Guthrie.} Okay. Thanks.

1946 Mr. Giese, can you explain what types of choices plans  
1947 face with the projected cuts under the ACA, what kind of  
1948 choices will the plans have under these projected cuts?

1949 Mr. {Giese.} Plans have a bunch of levers that they  
1950 have at their disposal to try to ward off these cuts. Those  
1951 changes or these adjustments include increases in benefits,  
1952 increases in premiums but of course limits the amount of  
1953 premiums and benefits they can change in a given year.

1954 They also can try to incorporate more care management  
1955 programs, but that sometimes is a leap of faith because in  
1956 their pricing, if they assume a certain level of care  
1957 management and don't achieve it, it could lead to not  
1958 successful results.

1959 Plans could exit, they could change their service area,

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1960 they could limit their network, making it a stronger network  
1961 with better physicians, more quality care that would help  
1962 lower their costs as well.

1963 Mr. {Guthrie.} But less choice for the patient?

1964 Mr. {Giese.} But less choice for their patients.

1965 Mr. {Guthrie.} So if you like your doctor, you might  
1966 not be able to keep that?

1967 Mr. {Giese.} Correct.

1968 Mr. {Guthrie.} Well, thank you, Mr. Chairman, and I  
1969 will yield back.

1970 Mr. {Pitts.} The chair thanks the gentleman and now  
1971 recognizes the gentleman from Illinois, Mr. Shimkus, 5  
1972 minutes for questions.

1973 Mr. {Shimkus.} Thank you, Mr. Chairman.

1974 I really appreciate your attendance. It is a great  
1975 debate. I know there is some diversity of views.

1976 [Slide]

1977 Mr. {Shimkus.} When we talk about budgeting, that is  
1978 the 2012 fiscal budget. The red is mandatory spending. You  
1979 will see Medicare is in there. The blue is discretionary  
1980 budget, which is what we fight and shut down government

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1981 about. Mandatory spending is spending that we can't control.  
1982 Medicare is part of that, Medicare, Medicaid, Social  
1983 Security, interest payments on the debt.

1984 I do this all the time because if you have a national  
1985 debt, it is based upon mandatory spending and Medicare is  
1986 part of that actuary problem that we have for future  
1987 generations.

1988 Do you know why we are having this debate on Medicare  
1989 Advantage? The President, through ObamaCare, cut \$716  
1990 billion from Medicare. And that is not disputed. Secretary  
1991 Sibelius was right there. She admitted in testimony to me in  
1992 front of this committee that she double counted Medicare  
1993 cuts.

1994 So now we have got to find the money. Now we are going  
1995 after seniors and programs that--we should have both. We  
1996 should have traditional fee-for-service for those who want it  
1997 and we should have the Medicare Advantage plans that we  
1998 promised them. This is the same debate we had last week on  
1999 Medicare D. We were able to stop the Administration from  
2000 hurting seniors and cutting Medicare D program. And so that  
2001 is why these hearings are very, very important.

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2002           And I know it is tough but, you know, facts and numbers  
2003 are hard to dispute. That is why we are here, because of the  
2004 attack on seniors from ObamaCare and the cutting of \$716  
2005 billion.

2006           Dr. Lew, only 20 percent of this cut has been actualized  
2007 right now. My guess is there is still 300 billion more  
2008 projected to go in the future. What do you think for this  
2009 big portion of seniors, if that is the true number, what is  
2010 the future of Medicare Advantage and Mr. Little and the plan  
2011 and healthcare that he enjoys writing out?

2012           Dr. {Lew.} Thank you for the question. As I said, we  
2013 just are starting to feel the pain of the cuts, 20 percent or  
2014 less, and as these cuts roll out, it is going to be very  
2015 difficult and very unlikely that we can continue at the same  
2016 level of programs and payments to physicians.

2017           Mr. {Shimkus.} So you are saying 300 billion more in  
2018 cuts, Medicare Advantage might not even be--

2019           Dr. {Lew.} We are looking at double digit cuts--

2020           Mr. {Shimkus.} --available as a program--

2021           Dr. {Lew.} --in 2014 plus 2015. I don't see how what  
2022 we can do can be sustainable.

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2023 Mr. {Shimkus.} All right. Let me go quickly because  
2024 time runs fast. And talk to me about the better healthcare  
2025 aspects of Medicare Advantage and the diversity of population  
2026 that you see in Medicare Advantage plans.

2027 Dr. {Lew.} Better healthcare, you know, we can reduce  
2028 hospitalizations, readmissions, we get better outcomes,  
2029 shorter lengths of stay.

2030 Mr. {Shimkus.} Saving dollars?

2031 Dr. {Lew.} Absolutely saving. I mean investment with a  
2032 great return. In terms of diversity in the markets that we  
2033 are in, it is all demographics.

2034 Mr. {Shimkus.} Explain that. I mean it is a senior  
2035 population so you are--

2036 Dr. {Lew.} Ethnicities, socioeconomic levels, rich,  
2037 poor.

2038 Mr. {Shimkus.} Rich, poor, different ethnic  
2039 backgrounds.

2040 Dr. {Lew.} Different ethnic backgrounds.

2041 Mr. {Shimkus.} Doesn't discriminate?

2042 Dr. {Lew.} No. No. It is all comers and it is not one  
2043 particular demographic.

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2044 Mr. {Shimkus.} All right. Let me ask you one more  
2045 question and no one has raised this, but because of the  
2046 funding problem, waste, fraud, and abuse is a big aspect on  
2047 Medicare spending, right? And I have always argued because  
2048 of fee-for-service, what do we do? We chase costs. We don't  
2049 manage the illicit theft of the Medicare fund at the point of  
2050 entry. We have to wait until there is 5, 10 years of data  
2051 before we go after the provider.

2052 You may not know this but I would like for all of the  
2053 panel to look at what is a better plan to address the waste,  
2054 fraud, and abuse that we currently know in Medicare today,  
2055 especially fee-for-service, and does Medicare Advantage  
2056 provide a more timely response to fraud? And I think, Mr.  
2057 Little, you kind of mentioned that, did you not?

2058 Mr. {Little.} Yes, sir. I get a monthly statement from  
2059 Humana showing everything I spent and they caution you on the  
2060 bottom if you have anything that you didn't have done, please  
2061 call us immediately.

2062 Mr. {Shimkus.} Dr. Lew, do you want to jump in?

2063 Dr. {Lew.} Yes. I think that is the value of a  
2064 population-based payment. It is a fixed payment that forces

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2065 us to manage the care quality, and so we contract with good  
2066 providers that won't commit fraud, whereas you have got a  
2067 fragmented fee-for-service that incentivizes volume, a lot of  
2068 potential for fraud.

2069 Mr. {Shimkus.} I appreciate it. Thank you, Mr.  
2070 Chairman.

2071 Mr. {Pitts.} The chair thanks the gentleman and now  
2072 recognizes the gentleman from Louisiana, Dr. Cassidy, 5  
2073 minutes for questions.

2074 Dr. {Cassidy.} Thank you, Mr. Chairman.

2075 I like Medicare Advantage because I think it aligns  
2076 incentives. Ms. Stein, I am sure we can find horror stories  
2077 with fee-for-service Medicare. I am a practicing doctor so I  
2078 know some of those horror stories. But the nice thing I like  
2079 is effectively it is a capitated payment which physicians are  
2080 at risk. If they do what I think Dr. Lew's organizations do,  
2081 they go two-sided risk with someone like Humana. So you  
2082 align incentives and frankly you make money by keeping people  
2083 out of the hospital and improving outcomes. If you don't,  
2084 you lose them.

2085 Now, I am struck, Dr. Lew. I am so frustrated I can't

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2086 open up my email account, but a physician practicing from  
2087 southern California sent me a document about the dual-  
2088 eligible project that is happening in southern California.  
2089 And in this dual-eligible project, so far, there is not a  
2090 company which is certified. They all have the poor rating  
2091 for quality and outcomes than the better rating. Now, that  
2092 is not your organizations. This is something specifically  
2093 set up for the dual-eligibles.

2094 And speaking to some folks like WellNet out of Austin,  
2095 Texas, I gather that they selectively go after the dual-  
2096 eligibles, that they improve outcomes, that they are focusing  
2097 resources knowing that if not, it breaks the bank. They are  
2098 a two-sided risk and so with prospective assignment of  
2099 patients and so that is where they earn the money, keeping  
2100 that patient out of the hospital and in better health. Would  
2101 you like to comment on that, please?

2102 Dr. {Lew.} Yes. Thank you, Mr. Cassidy. That is  
2103 absolutely correct. In our model we don't make money unless  
2104 we keep the population healthy. It is very simple.

2105 Dr. {Cassidy.} And the patient can change at the end of  
2106 the year and you have quality indicators, so it is not like

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2107 if you stiff them, you lose them, and if you stiff them, you  
2108 get dinged.

2109 Dr. {Lew.} Right. There is transparency in quality  
2110 metrics and so members can choose to opt out or switch to  
2111 another plan.

2112 Dr. {Cassidy.} So what percent can you give me of a  
2113 typical plan that you might represent would be dual-  
2114 eligibles?

2115 Dr. {Lew.} Health Net. Is that what you mean? An  
2116 actual plan?

2117 Dr. {Cassidy.} Medicare/Medicaid. Pick a typical plan  
2118 that if dual-eligibles, would they be 10 percent of an  
2119 enrollee group or 15 percent?

2120 Dr. {Lew.} Okay. I would say out of the senior  
2121 population it is probably 20 percent.

2122 Dr. {Cassidy.} Okay. Now, a lot of these would be in  
2123 the special needs plans as well?

2124 Dr. {Lew.} Special needs plan.

2125 Dr. {Cassidy.} Now, there has been specific cuts  
2126 targeted to the special needs plans. I assume that that  
2127 could in particular negatively impact folks who are most

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2128 vulnerable. Is that a correct intuition?

2129 Dr. {Lew.} Definitely. I mean these patients, you  
2130 know, by definition have more medical problems, chronic  
2131 illness, chronic disease, and require a lot more intensive  
2132 management. And so without an infrastructure to take care of  
2133 them, those are the ones that are really going to be hurt.

2134 Dr. {Cassidy.} Well, and my concerns I think in some of  
2135 the cuts they kind of make the home visit a second-class  
2136 visit. Again, I treat lot of cirrhotics, and cirrhotics  
2137 would typically be in a special needs plan. You want to go  
2138 home and you want to look at their diet and you want to look  
2139 at their cabinet. You want to see where their salt is coming  
2140 from. Cirrhotics are very sensitive to salt overload. I  
2141 kind of like that special needs visit, that home visit which  
2142 looks at that.

2143 Again, any comments on the impact of decreasing the  
2144 emphasis upon that?

2145 Dr. {Lew.} Yes. Well, that is again at a point--home  
2146 visits for the special needs patient that are bed-bound or  
2147 home-bound don't have transportation. It is essential that  
2148 we get to the home and take care of them to look at, you

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2149 know, cirrhotics that may have fluid overload and you have  
2150 got to see what they are eating and what their diet is. It  
2151 is important. You can assess a lot more from a patient in  
2152 the house than you ever can in the clinic.

2153 Dr. {Cassidy.} I once visited a patient of mine and I  
2154 saw he had a jar of salsa by his bed. I pointed out that  
2155 salsa has a lot of salt and so, oh, really?

2156 Dr. {Lew.} Um-hum.

2157 Dr. {Cassidy.} I figure most men are pretty ignorant  
2158 when it comes to their food and he was a man.

2159 Okay. Now, Ms. Stein, you probably disagree with what I  
2160 have been saying. What are your thoughts?

2161 Ms. {Stein.} My experience tells me, as does the  
2162 research in report by CMS, that people with high medical  
2163 needs and low income are disproportionately disenrolling from  
2164 Medicare Advantage plans.

2165 And I don't think I am here to talk about horror  
2166 stories. As I said earlier, I have no skin in this game. My  
2167 job is solely to represent low-income--

2168 Dr. {Cassidy.} But in fairness, you are mentioning the  
2169 person who went to Florida and his brain tumor wasn't

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2170 covered.

2171 Ms. {Stein.} One of your colleagues referred to my  
2172 office and, yes, there are problems in both models. But the  
2173 point is that we are paying as taxpayers and your colleague  
2174 earlier put up the pie chart which showed all the cost to  
2175 Medicare. And the CBO says that we are spending as taxpayers  
2176 \$150 billion more than we would if these individuals were  
2177 paid for in traditional Medicare.

2178 Dr. {Cassidy.} We can argue about that. I will point  
2179 out--and I will finish with this, Mr. Chairman--that when  
2180 Medicaid and Medicare pay differently, it disaggregates  
2181 payment. When you disaggregate payment, you disaggregate  
2182 care. So the dual-eligibles are a particular interest of  
2183 mine. That is why I have been looking at the demonstration  
2184 projects in southern California. I am very disappointed that  
2185 the companies that are running this are being rated so  
2186 poorly, and I do contrast that with some of the folks who are  
2187 doing kind of subcontracting for Humana and others and just  
2188 seeing that they are getting superior outcomes. I think that  
2189 kind of shows you the benefit of the special needs plans in  
2190 Medicare Advantage.

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2191           Ms. {Stein.} Actually, I suspect that my organization  
2192 represents more dually eligible home health and nursing home  
2193 organizations that anyone in the country. We have about  
2194 11,000 open cases right now. I just completed a training  
2195 seminar with all the home health agencies in Connecticut and  
2196 one of the questions was do the rules with regard to coverage  
2197 for home health--these are home health agencies--for people  
2198 in traditional Medicare also apply for people in Medicare  
2199 Advantage plans? And I said of course, yes. And there was  
2200 general agreement in the group of home health agency  
2201 providers that they have a much greater difficulty getting  
2202 access to coverage admission, particularly from the community  
2203 for people in Medicare Advantage plans--

2204           Dr. {Cassidy.} We are out of time--

2205           Ms. {Stein.} --and earlier--

2206           Dr. {Cassidy.} --but let me just say the nice thing  
2207 about it is that if the beneficiary doesn't like the MA plan,  
2208 they can change the next year. And that is the wonderful  
2209 thing about markets. We have to yield back. I am sorry.

2210           Mr. {Pitts.} The chair thanks the gentleman.

2211           Ms. {Stein.} That is only helpful if the person can

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2212 survive the year and that often doesn't happen.

2213 Mr. {Pitts.} The gentleman's time is expired.

2214 The chair recognizes the gentleman from New York, Mr.

2215 Engel, 5 minutes for questions.

2216 Mr. {Engel.} Thank you very much, Mr. Chairman and Mr.

2217 Pallone. Thank you for holding today's hearing.

2218 Let me try to put some things in perspective here. In

2219 2009, prior to the passage of the Affordable Care Act, the

2220 rates paid to Medicare Advantage plans exceeded that of

2221 traditional Medicare by approximately 18 percent. The

2222 Affordable Care Act required changes to Medicare Advantage

2223 payment rates to better align them with the costs associated

2224 with traditional Medicare. These changes were estimated by

2225 the Congressional Budget Office to save over \$135 billion

2226 over 10 years, something that I think my Republican friends

2227 would love. The ACA did not make any cuts to the benefits

2228 guaranteed to all Americans over the age of 65, whether or

2229 not they are in traditional Medicare or Medicare Advantage.

2230 So I think it is worth noting that while Republicans are

2231 aghast at this Administration that is moving forward and

2232 implementing the provider payment cuts included in the

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2233 Affordable Care Act, my Republican friends included and voted  
2234 in support of these very same provider payment cuts and their  
2235 budget proposals for the last several years. So to act  
2236 horrified about the changes that are being made to Medicare  
2237 Advantage now after voting to support them for years strikes  
2238 me as being disingenuous.

2239 I know in the past there have been concerns about  
2240 Medicare Advantage plans cherry picking and sticking to  
2241 enroll the healthiest of seniors leaving sicker beneficiaries  
2242 enrolled in traditional Medicare. Ms. Stein, in your written  
2243 testimony you mentioned a 2012 report from CMS that found  
2244 disenrollment by individuals from Medicare Advantage plans  
2245 back to traditional Medicare--and I am going to quote what  
2246 you wrote--`continues to occur disproportionately among  
2247 high-cost beneficiaries, raising concerns about care  
2248 experiences among sicker enrollees and increased costs to  
2249 Medicare.'

2250 So let me ask you, given your organization often assists  
2251 patients when they have issues with the Medicare program, can  
2252 you elaborate on some of the challenges sicker beneficiaries  
2253 sometimes have with their Medicare Advantage plans?

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2254 Ms. {Stein.} Yes, sir. Thank you very much.

2255 As Dr. Van de Water said a little earlier, there isn't a  
2256 lot of data about actual healthcare outcomes, but we do know  
2257 about disenrollment patterns, and you just expressed one of  
2258 them, which is that people at risk, low-income and people who  
2259 are ill, tend to disenroll from Medicare Advantage plans.  
2260 And that is because they have much more difficulty in  
2261 accessing a variety of specialists, different hospitals where  
2262 they might get the treatment they want, being able to move  
2263 around the country to be near their families because there  
2264 are network limitations, and a variety of other problems.

2265 And we very, very often get calls from people who think  
2266 that because the program itself is called Medicare Advantage,  
2267 that they have got something on top of their Medicare. And  
2268 when they find that they are ill and they need to go see a  
2269 specialist and the doctor isn't in their network, they are  
2270 terribly confused and didn't understand that when they  
2271 enrolled initially.

2272 And while I don't think that Medicare Advantage plans  
2273 are purposely closing their doors to people with particular  
2274 conditions, we do know that of the 2,250 doctors and

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2275 hospitals that were terminated in Connecticut alone, a very  
2276 small State, this year by an MA plan, a lot of specialists  
2277 who provide care for long-term illnesses, for instance,  
2278 nephrologists were on the termination list and particularly  
2279 in areas of low-income in Bridgeport and other areas in our  
2280 State leading to significant problems for people who are ill  
2281 with chronic conditions in MA plans.

2282           Mr. {Engel.} Well, thank you. My home State of New  
2283 York, which is of course right next to Connecticut, we have  
2284 countless doctors, hospitals, and health insurance plans that  
2285 have always made it their mission to provide quality care to  
2286 all New Yorkers regardless of whether or not their patients  
2287 have private insurance, Medicaid, Medicare, or pay for their  
2288 healthcare costs out of their own pockets.

2289           And we also have several Medicare Advantage plans which  
2290 focus on providing Medicare coverage for the dual-eligible  
2291 and low-income population in particular, often with more than  
2292 half of their plan participants eligible for Medicare and  
2293 Medicaid or receiving a low-income subsidy. Yet an  
2294 overwhelming number of these plans have found it challenging  
2295 to achieve the four stars needed to earn a bonus in 2015

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2296 despite having scored high on improvement measures.

2297           The let me again ask you, Ms. Stein or Mr. Van de Water,  
2298 how can we better incentivize Medicare Advantage plans to  
2299 take on more challenging beneficiaries so that these patients  
2300 enjoy the same access to high-quality plans and choices  
2301 available to healthier, more well-off beneficiaries?

2302           Mr. {Van de Water.} Well, I think the improved risk  
2303 adjustment, which we have talked about this morning, is  
2304 actually one of those ways. What we want to do is make sure  
2305 that health plans are encouraged to attract customers through  
2306 providing better quality service and not to make money  
2307 through attracting healthier beneficiaries. So while this  
2308 has been, you know, criticized on the one hand, actually I  
2309 think it is a very positive step.

2310           Mr. {Engel.} Thank you. Thank you, Mr. Chairman.

2311           Ms. {Stein.} I also suggest that--

2312           Mr. {Pitts.} The chair thanks the gentleman.

2313           Ms. {Stein.} --I think it was a MedPAC study in March  
2314 of 2013 that showed that about 20 percent of dual-eligible  
2315 special MA plans did score well on the star model rating, and  
2316 I think that we should look at what they are doing and

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2317 encourage the other plans to do that because apparently it is  
2318 possible to score well on that rating.

2319 Mr. {Pitts.} The gentleman's time is expired.

2320 Mr. {Engel.} Thank you.

2321 Mr. {Pitts.} The chair recognizes the gentleman from  
2322 Virginia, Mr. Griffith, 5 minutes for questions.

2323 Mr. {Griffith.} Thank you, Mr. Chairman, I would say to  
2324 you all, and appreciate you all being here. I would say that  
2325 my 83-year-old mother likes her Medicare Advantage plan. She  
2326 has had to pay a little bit more for it than she had in some  
2327 of the previous years. And even though we had Secretary  
2328 Sebelius here April of last year saying that the plans were  
2329 costing less nationwide, that hasn't been my mother's  
2330 experience.

2331 I surveyed, and it was a very small group of  
2332 constituents in my district that responded, but they  
2333 responded that theirs were either staying the same or going  
2334 up. So it does appear that there are some increases. Has  
2335 that been your experience as well, Mr. Little?

2336 Mr. {Little.} They didn't increase the base but I have  
2337 noticed this year that I am a paying 25 percent more for my

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2338 prescriptions.

2339 Mr. {Griffith.} Okay. I understand that. Mr. Giese,  
2340 you have been kind enough. I am just wondering if there is  
2341 something we haven't touched on? I have got some questions  
2342 for Dr. Lew; I don't have any questions for you, but I  
2343 thought maybe there was something that you have been sitting  
2344 here that you wanted to say that you haven't had an  
2345 opportunity to get out and I am going to give you that  
2346 opportunity.

2347 Mr. {Giese.} No, not really.

2348 Mr. {Griffith.} All right. I appreciate that. You  
2349 know, we sometimes have folks here and you have a lot of very  
2350 good witnesses and then somebody, because of the way the flow  
2351 of the discussion is going, they get left out and I always  
2352 hate to see that because I know that your time is just as  
2353 valuable as everybody else's. So I do appreciate that.

2354 Mr. {Giese.} A lot of people have read the report, I  
2355 can tell, and have quoted it and so--

2356 Mr. {Griffith.} Very good.

2357 Dr. Lew, according to the CBO, the ACA cut more than  
2358 \$300 billion from Medicare Advantage programs to spend on new

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2359 government programs that weren't necessarily for seniors.

2360 What types of important health benefits do you think that the

2361 MA plans help provide the seniors that would have to be cut

2362 if the proposed cuts occur?

2363 Dr. {Lew.} Well, we have to look at what the investment

2364 from prior years did into building up the model--

2365 Mr. {Griffith.} Um-hum.

2366 Dr. {Lew.} --the coordinator care model and all the

2367 additional benefits that the seniors get. And we would have

2368 to look at how can we even sustain that with the 10 percent

2369 cuts over the next 2 years? So you are looking at

2370 jeopardizing programs, reduced payments to our physicians,

2371 and subsequently, it could impact care to the seniors.

2372 Mr. {Griffith.} Now, I don't know anything about the

2373 Connecticut situation, but with those 2,200 some healthcare

2374 providers that were eliminated from an MA plan there, is it

2375 at least reasonable to assume that maybe they couldn't afford

2376 to pay those doctors the rates that they previously were

2377 paying and that maybe one of the reasons--I know it has got

2378 to be more complicated than that--but could that be one of

2379 the reasons why?

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2380 Dr. {Lew.} That is likely one of the reasons, sure.

2381 Mr. {Griffith.} Yes. In a recent letter, more than 140  
2382 physician groups called on Medicare officials to hold MA  
2383 rates flat. In the letter they said, ``cutting Medicare  
2384 Advantage year after year will result in deterioration of the  
2385 care coordination infrastructure and seniors will see a  
2386 deterioration of benefits, and we are worried we will  
2387 ultimately move back into fragmented fee-for-service care  
2388 delivery models. This would be a bad outcome for seniors and  
2389 a step backward on the healthcare delivery system.'' You  
2390 have been saying the same thing--

2391 Dr. {Lew.} Saying exactly that same thing, yes.

2392 Mr. {Griffith.} And can you elaborate on that some?

2393 Dr. {Lew.} Yes. Well, I think that rather than going  
2394 backwards is we need to use the platform that we have built  
2395 to build more, to build more coordinating care. And even  
2396 some of the newer models within fee-for-service such as ACOs,  
2397 medical homes, you know, how can we take all that we have  
2398 learned from the Medicare Advantage coordinated care model,  
2399 how can we use that to build the newer models that we are  
2400 trying to do in fee-for-service?

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2401           But this impacts all of the healthcare delivery system.  
2402   It is not just Medicare Advantage. It is care for everybody  
2403   in the country. And so, you know, if we want to really  
2404   transform the delivery system, we don't want to touch  
2405   Medicare Advantage and all that we have built.

2406           Mr. {Griffith.} All right. I appreciate that very  
2407   much.

2408           Thank you all again, and, Mr. Chairman, I yield back.

2409           Mr. {Pitts.} The chair thanks the gentleman and now  
2410   recognizes the ranking member of the full committee, Mr.  
2411   Waxman, 5 minutes for questions.

2412           Mr. {Waxman.} Thank you very much, Mr. Chairman.

2413           I want to point out that there are a lot of things going  
2414   on at the same time, additional subcommittee and another  
2415   committee that I am involved with, so I haven't been here the  
2416   full time.

2417           But, Mr. Chairman, I would like to ask unanimous consent  
2418   to insert my opening statement in the record.

2419           Mr. {Pitts.} Without objection, so ordered.

2420           [The prepared statement of Mr. Waxman follows:]

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2421 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
2422 Mr. {Waxman.} And there is an awful lot of fear-  
2423 mongering going on about Medicare Advantage program and it is  
2424 not based on the facts. The Democratic staff released a memo  
2425 this morning. The first one is that independent analysts and  
2426 the financial markets do not agree with the industry's dire  
2427 claims about the future of Medicare Advantage. And then the  
2428 second point is that this scare campaign is not the first  
2429 time the industry has cried wolf about commonsense reforms  
2430 being flat wrong. The memo looks at the facts, not anecdotes  
2431 or claims by industry-backed groups.

2432 And here are the facts we point out: Since the ACA was  
2433 enacted, Medicare Advantage premiums are down almost 10  
2434 percent and enrollment is up 30 percent. After CMS released  
2435 its payment notice and the industry claimed the sky was  
2436 falling, independent experts examine the issue and found that  
2437 the industry was wrong. They predict the future is bright  
2438 for Medicare Advantage, and as a result, insurer stock rises  
2439 have risen, not fallen, since the CMS announcement.

2440 And this is not the first time the industry has cried  
2441 wolf on Medicare Advantage or other commonsense reforms.

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2442 They said that the ACA would destroy Medicare Advantage but  
2443 it is stronger than ever. They said the requirement that  
2444 they pay back rebates if they spend more than 20 percent of  
2445 premiums on profits and overhead would put patients at risk  
2446 and it did not. Instead, it has resulted in more than \$1.5  
2447 billion in rebates and \$5 billion in lower premiums.

2448 Mr. Chairman, I would like to ask unanimous consent to  
2449 insert the memo I referred to in the record.

2450 Mr. {Pitts.} Without objection, so ordered.

2451 [The information follows:]

2452 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|

2453           Mr. {Waxman.} And the next thing I want to ask in the  
2454 time I have is, Mr. Van de Water, we have heard a lot today  
2455 about the Medicare Advantage changes in the Affordable Care  
2456 Act. These changes strengthen the program in my view and  
2457 help to improve the solvency of the Medicare trust fund as  
2458 well preserving Medicare's health for a number of years. If  
2459 you listen to my colleagues on the other side of the aisle,  
2460 you would think these cuts were killing the program, but in  
2461 fact, this has not been the case. Could you comment on what  
2462 has happened in Medicare Advantage enrollment and premiums  
2463 since the Affordable Care Act was enacted?

2464           Mr. {Van de Water.} Yes, Mr. Waxman, I would be happy  
2465 to. In fact, in my prepared statement I cite some of the  
2466 same figures that you have just reiterated about how  
2467 enrollment has indeed grown over the past several years and  
2468 how premiums have actually gone down. And you are absolutely  
2469 right that the efficiencies in Medicare payments that were  
2470 enacted as part of the Affordable Care Act had indeed made an  
2471 important contribution to strengthening Medicare's Hospital  
2472 Insurance trust fund. My recollection is that the CBO

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2473 estimate is that the Affordable Care Act extended the life of  
2474 the Hospital Insurance trust fund by roughly 8 years.

2475 Mr. {Waxman.} Well, if the health insurance companies  
2476 like getting more money and the 30 percent of beneficiaries  
2477 who are in these plans are generally happy, why not keep  
2478 overpaying them?

2479 Mr. {Van de Water.} Well, one of your colleagues on the  
2480 other side of the aisle showed a chart a few minutes ago  
2481 showing that, you know, Medicare, as we all know, is a  
2482 substantial part of the federal budget and we are concerned  
2483 about reducing projected large deficits. So we--

2484 Mr. {Waxman.} Well, that gives us ideas about how we  
2485 should make the elderly pay more for their healthcare costs  
2486 but they don't want to reduce the cuts of overpayments to  
2487 these Medicare Advantage plans.

2488 We have heard a great deal about ObamaCare cuts to  
2489 Medicare Advantage, but didn't the Republican budget led by  
2490 Representative Paul Ryan include the very same so-called cuts  
2491 that were in the Affordable Care Act?

2492 Mr. {Van de Water.} Yes, it did.

2493 Mr. {Waxman.} I have been in Congress for 40 years.

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2494 That is why I am retiring, among other reasons. And I  
2495 remember when we first made Medicare managed plans available  
2496 for Medicare reimbursement if the beneficiary chose to go  
2497 with such plans. And we had it less than what the fee-for-  
2498 service would be because they selected out some of the lowest  
2499 risk people and the fee-for-service were covering the highest  
2500 risk. We went from a little less than what fee-for-service  
2501 was to way more than the fee-for-service without doubt in my  
2502 opinion as I look at this program.

2503 Medicare Advantage is important. It serves a very  
2504 useful purpose to beneficiaries free to choose it and many of  
2505 them are very happy, but that is just not a reason to overpay  
2506 them.

2507 Thank you, Mr. Chairman. I yield back my time.

2508 Mr. {Pitts.} The chair thanks the gentleman and now  
2509 recognizes the gentleman from Florida, Mr. Bilirakis, 5  
2510 minutes for questions.

2511 Mr. {Bilirakis.} Thank you, Mr. Chairman. I appreciate  
2512 it very much. And I have been going back and forth as well  
2513 from CMT, but this is a very important hearing.

2514 Mr. Giese, 40 to 45 percent of my seniors in my

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2515 district--and I have over 100,000 seniors in the Tampa Bay  
2516 area; I represent that area, the 12th Congressional District  
2517 of Florida--on Medicare Advantage, 40 to 45 percent. That is  
2518 higher than the national average. So they really love their  
2519 plans and we love the fact that they have all these choices.

2520 I am concerned with some of the changes that CMS is  
2521 doing to their risk model. It seems to me that CMS is  
2522 ignoring or not factoring in certain chronic conditions when  
2523 determining their risk model. When considering the risk  
2524 adjustments, CMS seems to ignore or not count patients with  
2525 certain chronic conditions. What is the impact of the 2014  
2526 changes to the risk model on sick and frail Medicare  
2527 beneficiaries and particularly to those on the special needs  
2528 plans area?

2529 Mr. {Giese.} Well, changes to the risk model result in  
2530 reductions in payments to plans, which means the plans have  
2531 to react by increasing benefits to everyone, but in  
2532 particular to the poor and actually sicker people who pay the  
2533 cost-sharing. So these people have to pay more as a result  
2534 of changes to the risk adjustment model.

2535 Mr. {Bilirakis.} Thank you. The next question is for

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2536 Dr. Lew. In 2015 advance notice CMS eliminated the home  
2537 health assistance assessments as part of the risk model.  
2538 This is what I understand. As I understand their change, CMS  
2539 would only count the diagnosis identified in a home visit if  
2540 and when it was confirmed in a later in-office doctor's  
2541 visit. Can you explain the dangers of the payment change  
2542 related to the home-based health assessments, especially for  
2543 the elderly?

2544 Dr. {Lew.} Yes, thank you. As I had mentioned, home  
2545 visits are part of the continuum of care and you take out  
2546 home care and the benefits, it leaves a gap. If you are only  
2547 going to count a visit or a diagnosis obtained at a visit if  
2548 the patient is followed up in the office, a lot of these  
2549 patients go to the hospital because, you know, that is the  
2550 value of going to the home, early detection, catching  
2551 something as opposed to a 911 phone call and something a lot  
2552 more serious. The patient can be sent to the hospital for  
2553 care.

2554 So, you know, to only count a diagnosis where the  
2555 patient has a follow-up visit in the doctor's office, that is  
2556 very narrow in scope and it really discounts the advantage

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2557 and the benefits of a home visit.

2558 Mr. {Bilirakis.} Thank you very much.

2559 Mr. Giese, this question is for you. For all these cuts  
2560 to Medicare Advantage, these plans are dependent on the star  
2561 ratings to survive. However, it seems to me that special  
2562 needs plans may be disadvantaged because of their unique  
2563 population. Can you describe some of the challenges that  
2564 special needs plans face in the star rating program?

2565 Mr. {Giese.} Sure. First of all, a lot of the star  
2566 ratings are based on survey data and sometimes it is hard to  
2567 get to these people. Some of them are homeless, some of  
2568 them, they don't know where they live. So it is hard to find  
2569 them in these surveys. So special needs plans tend to have  
2570 lower star ratings because we can't find the people and they  
2571 don't respond well to the survey as well.

2572 Mr. {Bilirakis.} Okay. Now, for Dr. Lew and Mr. Giese  
2573 again, if the proposed cuts occur, what kind of benefits  
2574 would no longer be provided to seniors in your opinion, an  
2575 example of some of the benefits that they might lose if the  
2576 cuts take place?

2577 Dr. {Lew.} Well, from our delivery side, you know, I

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2578 think you are going to jeopardize all of the extra home  
2579 visits perhaps. I mean that would be one example. I mean we  
2580 have a lot of programs built around, again, the continuum of  
2581 care, visits from pharmacists and social workers, which have  
2582 sufficient costs. And, you know, if we are on a budget and  
2583 our revenue is reduced, that is obviously going to jeopardize  
2584 a lot of our programs.

2585 Mr. {Giese.} Remember that cuts and benefits are not  
2586 just additional benefits over Part A and B; they are also  
2587 changes in cost-sharing. So if the plan has to increase  
2588 their cost-sharing, that is a reduction in benefits.

2589 Mr. {Bilirakis.} Okay. Very good. Thank you very  
2590 much. I appreciate it.

2591 I yield back, Mr. Chairman.

2592 Mr. {Pitts.} The chair thanks the gentleman. That  
2593 concludes the questions from the Members who are present.  
2594 There are several committee meetings going on so other  
2595 Members will have questions. We may have follow-up  
2596 questions. We will submit those to you in writing. We ask  
2597 that you promptly respond.

2598 And I recognize the ranking member for a UC request.

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2599           Mr. {Pallone.} Mr. Chairman, I would just ask unanimous  
2600 consent to submit for the record some Democratic comments in  
2601 a letter to CMS.

2602           Mr. {Pitts.} Without objection, so ordered.

2603           [The information follows:]

2604           \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|

2605 Mr. {Pallone.} Thank you.

2606 Mr. {Pitts.} Thank you very much for your testimony.

2607 This is a very important issue and we appreciate you coming  
2608 today.

2609 And I remind Members that they have 10 business days to  
2610 submit questions for the record. Members should submit their  
2611 questions by the close of business on Thursday, March 27.

2612 Without objection, the subcommittee is adjourned.

2613 [Whereupon, at 12:18 p.m., the subcommittee was  
2614 adjourned.]