

Answers to Additional Questions for the Record
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health Hearing on “Setting Fiscal Priorities”
December 9, 2014

Questions from The Honorable Joseph R. Pitts

- 1) **In addition to the newly created and expanded entitlement programs in the Affordable Care Act, the law included a number of mandatory programs not subject to annual review by Congress. One program, the Prevention and Public Health Fund, was given a permanent mandatory appropriation – putting the program on permanent auto pilot. While I’m a strong proponent of prevention strategies and programs in health care, I think Congress should do its job and annually scrutinize whether taxpayer dollars are being spent wisely. As a general matter, do you think it makes sense for Congress to put more federal programs on the mandatory side of the ledger or should Congress take a more active role in annually reviewing the cost and benefits of federal programs?**

In general, I’m not a fan of putting more programs on autopilot, both because I think it reduces Congress’s ability to make decisions and because these programs tend to run up the deficit. Last year, mandatory spending and interest payments ate up 77 percent of total tax collections, meaning almost everything Congress actually decided to do in the last couple of years was paid for on a deficit-financed basis.

Of course, this doesn’t mean that mandatory spending is never appropriate or that no program should ever be moved over to the mandatory side of the budget, but in general I do think programs that are currently part of the appropriations process should remain there unless there is a compelling reason to make them mandatory.

Meanwhile, there are also a number of ways to reduce the “auto-pilot” nature of various mandatory programs, ranging from putting them into the discretionary budget, to requiring occasional reauthorization, and to simply ensuring better oversight.

With regards to the prevention fund specifically, I think Congress has a number of options, including cutting annual prevention fund spending through CHIMPs (changes in mandatory spending) thus allowing the money to be used on other appropriations measures.

- 2) **Under Medicare Parts B and D, upper income beneficiaries pay higher premiums based on their higher levels of income. [Part B has been income-adjusted for many years, and Part D was further income adjusted in the Affordable Care Act/"Obamacare."'] The president's FY2015 budget endorses a policy of further increasing an income-adjusted Medicare premiums until capping the highest tier at 90 percent. As the president said in that budget, "this proposal would help improve the financial stability of the Medicare program by reducing the federal subsidy of Medicare costs for those who need the subsidy the least." Charging wealthier seniors more is a policy that has often enjoyed bipartisan support, so do you believe this would be a useful offset for a large SGR package?**

I think it's quite reasonable to ask wealthier seniors to pay more for their Medicare benefits, and certainly we shouldn't be reducing their premiums – which is effectively what happens under current law starting in 2020. Depending on what policy you pursue, you could easily save anywhere from \$20 billion to \$100 billion by increasing income-related premiums.

Personally, my preference would be that policies to reform the SGR focus on slowing the growth of overall health spending, which on the beneficiary side would suggest changing deductibles and copays that influence behavior rather than premiums, which would simply shift costs. Still, I think increasing income-related premiums is a sensible cost shift that would better allocate our scarce health resources, and could be part of an SGR reform bill.

- 3) **GAO and the HHS Inspector General have reported for years on various financing arrangements that allow states to obtain billions of dollars in additional federal Medicaid matching funds without a commensurate increase in state funds to finance the nonfederal share of Medicaid. One such arrangement involves taxing health care providers. In his budget, the President has called for phasing down the Medicaid provider tax threshold from the current level of 6 percent to 3.5 percent. The president's Fiscal Commission recommended eliminating the use of provider taxes for providing the nonfederal share of Medicaid funding. What do you think about this policy recommendation and about state pushback on the policy?**

States often engage in "creative financing" to artificially boost the matching Medicaid payments they get from the federal government, and the "provider tax" is one of the more egregious examples of this. The policy involves states imposing a tax on Medicaid providers and using that tax revenue to increase pre-tax payments to those providers, in

turn deriving greater matching payments from the federal government. Essentially this gimmick allows states to report paying providers a higher amount than they actually pay, receiving a federal match based on that higher level.

Unfortunately, this gimmick is so widespread that I think eliminating it immediately would lead to serious resistance from the states. To be sure, doing so should not be regarded as “changing the deal” to states, since it simply would make sure they are receiving the amount intended under current law; nevertheless, it would represent a significant adjustment for many states. To resolve this, the Fiscal Commission recommended very gradually phasing out this gimmick.

Currently, states can tax providers up to 6 percent of their gross revenue, up from 5.5 percent as recently as 2011. The threshold could be restored to 5.5 percent almost immediately, but then gradually reduced to a nominal amount over ten or twenty years. That should give states plenty of time to adjust their finances and get out of the business of reporting inflated Medicaid costs to the federal government.

- 4) Under the Medicaid disproportionate share hospital (DSH) program, states make payments to hospitals treating large numbers of low-income patients in order to recognize the disadvantaged financial situation of such hospitals because low-income patients are more likely to be uninsured. Industry reports have indicated that hospitals are yielding tremendous financial gains from Medicaid expansion. Thus, now that the Affordable Care Act has been implemented, are DSH payments even necessary in states that expanded Medicaid?**

There are still a number of uninsured Americans even under the ACA, but the need for DSH payments has clearly declined. I’m not ready to weigh in on the level of DSH payments that is most appropriate, but certainly we should be having the discussion over how much funding to dedicate to DSH and what form that funding should take.

- 5) There have been five bipartisan plans to help save Medicare introduced in this president’s term: (1) Rivlin-Domenici, 2) Rivlin-Ryan, 3) The Fiscal Commission, 4) Simpson-Bowles’s own plan, and (5) a plan by former Senator Joe Lieberman and Senator Tom Coburn. The Lieberman-Coburn plan has been proposed in legislative text and was scored by the Actuary of the Medicare program. The Actuary said that, if this legislation was adopted, it would prevent Medicare’s insolvency for decades, and reduce seniors’ premiums so they would be lower than under current law. Can you**

talk about what you think are the most viable pieces of these five proposals for Congress to adopt?

In addition to the five plans you mention which should help to control Medicare costs, CRFB has its own “PREP Plan”, which includes a significant package of Medicare reforms to pay for reforming the SGR. As best as I can tell, all six of these plans have two elements in common. First of all, each would reform Medicare’s cost-sharing rules to move away from the current patchwork system toward one with a unified Part A and Part B deductible, fairly uniform co-insurance charges, and catastrophic caps to prevent seniors from falling into medical bankruptcy. And second, all six plans would restrict the use of costly Medigap plans, which provide “wrap-around coverage” that often masks important price signals and in doing so drives up costs for beneficiaries and the Medicare program.¹

Although details must be worked out – and actually differ in each of these proposals – I think cost-sharing and Medigap changes should both be considered viable options to help reduce Medicare costs or pay for SGR reform.

In addition to cost-sharing changes, many of the six Medicare reform proposals would reduce future payments to post-acute care providers, which MedPAC and others believe are currently too high. The PREP plan does so by “bundling” post-acute and inpatient care costs and then haircutting the size of the bundle, while the other plans tend to make reductions within the fee-for-service framework.

- 6) According to information released by the Actuary of the Centers for Medicare and Medicaid Services, drug spending is projected to hold steady for the foreseeable future at about 10 to 15 percent of National Health Expenditures. However, the Actuary did note that the emergence of specialty drugs presents cost challenges for some payers. This is especially the case in Medicaid, where individuals receiving life-saving cures may churn in and out of the program based on their income. Unlike the defacto price control in the Medicaid program, the Medicare program has the benefit of a competitive program with varying formularies and plans, where a senior can pick a plan that meets his or her needs. So, have any of you thought about targeted policies to give plans and states more control over their drug spending?**

¹ <http://crfb.org/document/prep-plan-paying-reform-and-extension-policies>

The high cost of specialty drugs is already becoming a difficulty for Medicaid and state budgets. Introducing more competition may be able to help some to reduce prices for some types of drugs; however, because many of these drugs possess a near-monopoly there are probably limits to what can be done on this front. There are a few other avenues that could be pursued to help Medicaid deal with such high-cost drugs. 1) Strong clinical prior authorization criteria could explicitly be allowed, which is already being undertaken in many states. Similarly, the federal government could provide legal protections to states pursuing step therapy plans in order to access certain drugs. 2) The current Medicaid drug rebate could be made even stronger to focus on drugs with little to no competition. 3) Patent exclusivity periods can be reduced, which would allow generic competition more quickly. 4) A binding arbitration process could be introduced in which a neutral arbitration judge would be required to determine the appropriate price based on evidence presented from both parties – the state and the drug manufacturer.

- 7) **CBO has estimated that repealing or delaying the IRS' authority to fine Americans for failing to buy government-approved coverage, otherwise known as the individual mandate, would result in tens of billions of dollars in savings for federal taxpayers. Taking away IRS' authority to punish Americans under Obamacare seems like a common sense proposal to limit government and save taxpayer dollars. One objection to this idea we often hear is that an individual mandate is necessary to cover pre-existing conditions. However, isn't it true that we can cover pre-existing conditions without an individual mandate while ensuring market stability through other mechanisms? (e.g. Medicare late enrollment penalties, high-risk pools, continuous coverage underwriting protections, etc.)**

I think there are a number of options available to maintain healthy risk pools, all with their own set of costs and benefits. If Congress chooses to replace the individual mandate, I'd advise a thoughtful process of weighing and negotiating the various options so we know the risks and challenges going in.

- 8) **The Affordable Care Act included \$1 trillion in tax hikes and more than \$700 billion in reductions in Medicare, spent on government programs not for seniors. The House recently passed a bill using tax increases and Medicare cuts to offset increases in Medicare and Medicaid spending. Can you talk about challenges with or any concerns with using tax hikes to pay for increased Medicare or Medicaid spending – rather than using targeted, common-sense Medicare and Medicaid reform policies?**

Our fiscal situation is severe enough that we will probably need both higher revenue and lower Medicare spending, which can come from a combination of cuts and reforms. I worry about dedicating too much Medicare or tax expenditure savings to new programs, and therefore leaving too little to pay down the debt. At the same time, policymakers should be able to address new priorities. Part of the problem with our current budget is that so much is on unsustainable autopilot that there is little room for new initiatives.

Ideally, we would work to substantially reduce the automatic growth in the budget (including tax expenditures) to leave more room for new priorities. Given the reality of where we are, a first logical step would be to begin by paying for our “must have” policies, then working to put the debt on a sustainable path, then identifying new needs and priorities and how to pay for them.

In the context of health care, that means permanently replacing the Sustainable Growth Rate (SGR) with health-related savings, then identifying further reforms to slow health care cost growth, then turning our attention to new health needs and priorities.

- 9) **The Affordable Care Act/“Obamacare” took more than \$700 billion to spend on new government programs not for seniors. One of the big pay-fors for the bill was across-the-board annual reductions in the growth rates of Medicare payments for hospitals. Under the law, these cuts are scheduled to continue to be reduced each year, permanently. As a result, the Actuary of the Medicare program has said that if these cuts continue as outlined in the law, either (a) up to 15 percent of hospitals could close and many hospitals would stop taking Medicare patients, or (b) Congress reverses the cuts, increasing the rate of Medicare spending and accelerating the insolvency of the program. In your view, would it be better to scrap these reductions and replace them with other policies – and if so, why?**

The short answer is that while I do not believe these growth rate reductions are sustainable on a permanent basis, I do think they can help to keep cost growth under control in the medium term and I would support replacing them in part, but only if equal-sized savings were identified.

As you mention, the Affordable Care Act included what is often called “productivity adjustments,” but really amounts to a permanent reduction in the growth rate of nearly all non-physician provider payments under Medicare. The idea behind these adjustments is that Medicare providers should be able to accomplish what most other

actors in the economy do and become more productive in their delivery of services over time. A more modest version of these adjustments had been proposed prior to the ACA by the Bush Administration.

Certainly in the near-term, these productivity adjustments are helping to make Medicare more affordable, both by allowing the taxpayer to capture what productivity gains do exist in the health arena and by indirectly slowing the growth of what many view as overpayments on a variety of services. But I think there is a serious question regarding whether this slower growth rate can be sustained on a permanent basis.

The adjustments effectively reduce growth rates by approximately 1.1 percentage points per year, which means a 10 percent reduction after 10 years, a 20 percent reduction after 20, and a 28 percent reduction over 30. I think it's reasonable to assume providers can absorb and learn to live within these levels for a while, but probably not indefinitely. This is especially true if private insurance health care prices continue to grow and the gap between private and public payments grows to be too wide.

To address this concern, I would make three broad suggestions.

First, be able to recognize the difference between when these adjustments become *politically* difficult to sustain and when they become *economically* difficult. Focus on the latter.

Second, work to slow health care costs economy-wide. The slower private spending is growing, the easier it will be to sustain reductions in Medicare growth.

And finally, develop institutions over the long run that let us regularly swap some of these across-the-board growth rate adjustments with more targeted reforms. For example, we could make it an annual practice for Congress to put forward legislation compiling MedPAC's most recent short-term payment reforms and swap those for an equal-sized reduction in that year's productivity adjustment.

10) MACPAC has recommended creating a statutory option for states to implement 12-months continuous eligibility for children in CHIP. To what extent does a 12-month continuous eligibility option result in CHIP coverage for individuals from families with incomes above the CHIP eligibility thresholds? How does a 12-month continuous eligibility policy affect the required premiums and cost sharing for an

enrollee? Could it result in an enrollee paying more or less than required based on their current income?

Unfortunately, I'm not an expert on the CHIP program and probably don't have the appropriate information to be able to answer this question sufficiently.

11) Under the ACA households at 400% of federal poverty level (with income of nearly 100k) have and will receive subsidies to purchase coverage on the exchange. In your testimony, you note that reducing this subsidy level to 300% of federal poverty would result in savings of nearly \$181 billion. As Congress considers proposals to reduce federal spending, doesn't it make sense to first look at federal subsidies for upper-middle class households?

In the health care arena, I think it makes sense to first look at where we can change incentives to actually slow the growth of federal and total health care spending. Once we've done our best to "bend the cost-curve," we should turn to finding ways to better allocate our scarce health care resources. Certainly that means looking at spending currently going to upper- and upper-middle class households and seniors, especially in Medicare. I don't want to specifically endorse the CBO option I cited to eliminate ACA subsidies above 300% of the poverty line, but I do think it's reasonable to take a hard look at how much we want to be spending on individuals above that income level.

12) One objection to the above proposal is that Americans above 300% of federal poverty will receive no subsidies, but still be forced to pay for ACA's expensive benefit mandates – leaving them without affordable coverage options. To address this issue, would it also make sense to allow any American to buy a catastrophic plan and reduce other ACA benefit mandates to promote affordability?

Once we as a society decide we want nearly every citizen to buy or be provided adequate health insurance – which the ACA effectively does – we must answer the question of what constitutes "adequate." There is of course no perfect or objectively true answer to this question. Had the ACA set its mandate to require everyone be in a plan with no out of pocket costs and no network restrictions, I think we would all agree that criteria was too stringent. And had it allowed insurance that didn't kick in until a person had already spent \$1 million out of pocket, I don't think many of us would view the bill as truly requiring adequate coverage. Identifying the sweet spot in between is, by its very nature, a balancing act. And while in general I'm supportive of skin in the game for health consumers that can afford it, I think it is up to Congress to decide

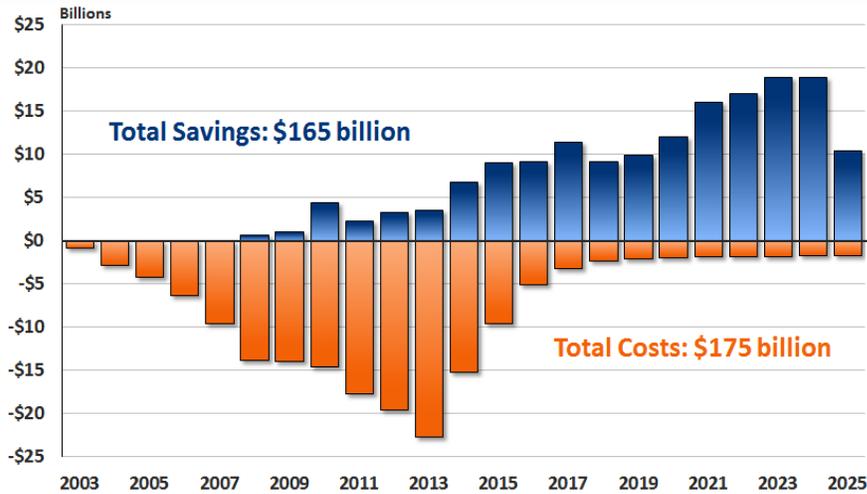
whether the ACA allows too much, too little, or just the right amount of cost-sharing under current law.

- 13) Physicians face a 21 percent cut in Medicare payments this April as a result of the Sustainable Growth Rate (SGR). A one-year “doc fix” to avoid this cut would cost about \$15 billion, and a permanent fix, depending on the details, could cost anywhere from \$120 to \$180 billion. A lot has been made about the need to “pay for” this fix. Isn’t this just a budgetary snafu? Why should we have to offset stopping cuts to doctors that we all know won’t actually happen?**

Although the Sustainable Growth Rate (SGR) hasn’t worked quite as intended, it has actually helped reduce Medicare costs by encouraging the enactment of more thoughtful changes to the program. Failing to pay for legislation replacing the SGR would break with ten years of precedent, add hundreds of billions of dollars to the debt over the next couple of decades, increase Medicare premiums for most beneficiaries, and waste a rare but valuable opportunity to make positive reforms to the Medicare program.

For context, the SGR was originally created in 1997 to slow the growth of Medicare payments to physicians. Since 2003, however, it has called for increasingly deep cuts to physician payments that policymakers have waived through “doc fixes” over and over again. Importantly, though, *doc fixes have been paid for 98 percent of the times* they have been implemented since 2004. These pay-fors have generally come from within Medicare, and included many important recommendations from MedPAC and others, as well as a number of small structural reforms that have helped, on the margins, to slow health care cost growth.

SGR Has Resulted in \$165 Billion in Deficit Reduction



Note: Estimates are the cumulative totals of "doc fix" bills passed since 2002, as scored by the Congressional Budget Office before final passage, extrapolated beyond 10 years by CRFB.



According to our analysis, all of the doc fixes since 2003 have added about \$175 billion to the deficit through 2025, but included offsets that saved \$165 billion over that same time period.² The \$21 billion of offsets in the last doc fix included a change to help HHS set more accurate physician payments, a new value-based purchasing program for skilled nursing facilities, and the introduction of market prices into clinical lab payments.³

To be sure, the savings and improvements accompanying past doc fixes have been relatively small. And setting physician payments one year at a time with a formula that simply doesn't work is no way to budget for the long term. That's exactly why Congress should take advantage of the current low cost of SGR reform to combine the creation of a new formula with more significant Medicare reforms that truly help to "bend the health care cost-curve."

These reforms would only need to save \$150 to \$200 billion in total, which is less than half the magnitude of the changes in the President's budget and less than one third the size of the changes in the most recent Simpson-Bowles plan. Reforms could also represent a win-win for beneficiaries and taxpayers alike by focusing on reforms which truly change the incentives within the health care system instead of simply shifting who pays and how much.

² <http://crfb.org/blogs/actually-sgr-has-slowed-health-care-cost-growth>

³ <http://crfb.org/blogs/sgr-continues-slow-health-care-cost-growth>

In fact, CRFB's own PREP Plan to offset the doc fix, which reformed both cost-sharing and provider reimbursement rules, would reduce out of pocket costs for the average beneficiaries, even as it saved the Medicare program roughly \$160 billion.

14) Medicare spending grew last fiscal year by only 2.7 percent – the fourth lowest growth rate in history – despite a 3.8 percent increase in the number of beneficiaries. In large part because of these recent trends, the Congressional Budget Office (CBO) has revised down its future health care cost projections significantly. The agency now projects Medicare spending between 2012 and 2021 to be more than \$500 billion lower than projections they made in March of 2011. In light of this good news, why should Congress be concerned about an increase in health care costs, and Medicare spending in particular?

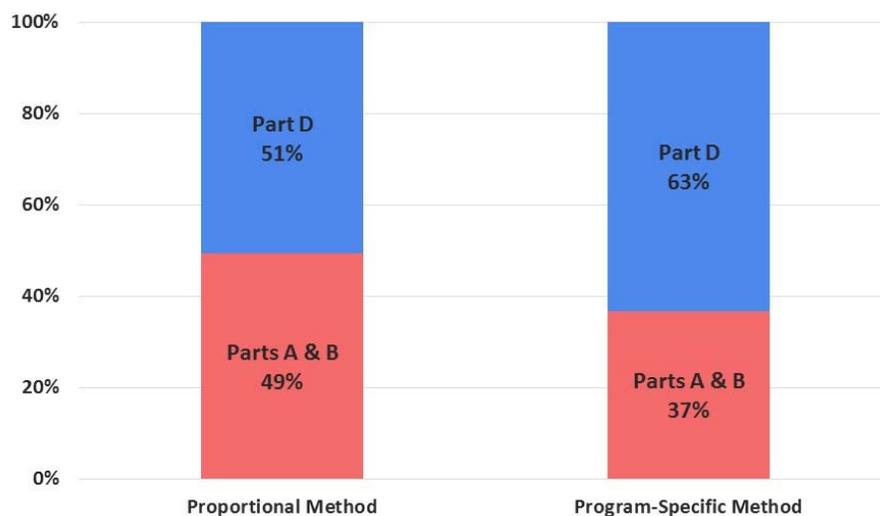
The recent slowdown in Medicare cost growth is encouraging, but it is certainly no reason to declare victory and stop pursuing further reform.

First of all, a large portion of the recent slowdown is likely temporary. For example, we have calculated that Medicare would have grown more than 2 percentage points faster last year if not for one-time legislated cuts such as the “sequestration.”⁴ In addition, the fact that the baby boom population is just now entering the Medicare program and therefore temporarily reducing the average age (and therefore average cost) of the Medicare population. On top of this, the “great recession” and the low inflation and growth that accompanied it likely had some direct or indirect impact on Medicare's growth rate. And finally, a recent one-time “patent cliff” for prescription drugs has temporarily slowed down Medicare cost growth – explaining why Medicare Part D is responsible for between one half and two thirds of the slowdown despite comprising only one tenth of the program.⁵

⁴ <http://crfb.org/blogs/medicare-registers-fourth-lowest-growth-rate-program-history-2014>

⁵ <http://crfb.org/blogs/another-way-look-medicare-slowdown>

Part D Constitutes Majority of the Medicare Growth Slowdown



Source: CBO, CRFB calculations

Proportional method compares 2010-2014 growth rate in each part to overall 2007-2010 Medicare growth.

Program-specific method compares each part's 2010-2014 growth rate to its own 2007-2010 growth rate.



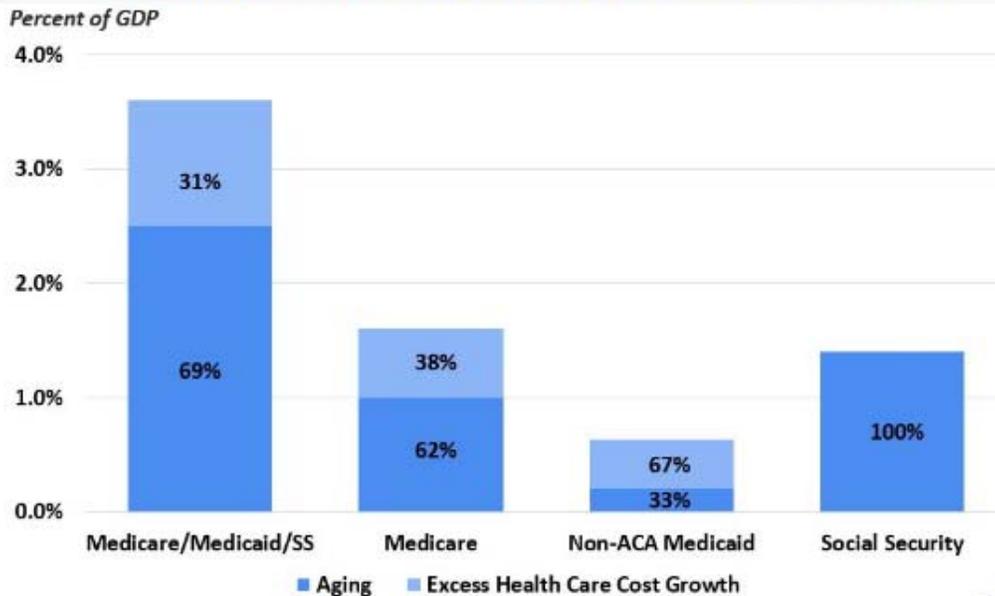
Second, the slowdown itself may depend in large part on the expectation of future health reforms. Former CBO and OMB Director Peter Orszag subscribes to this theory, which, if true, means that policymakers must continue to reform the payment and delivery system simply to prevent the slowdown from reversing itself.⁶

Third, policymakers will need to identify policies to offset an SGR fix and maintain the solvency of the Medicare Part A trust fund almost regardless of overall growth rates.

Fourth, it is important to remember that the key driver of Medicare spending over the next few decades is not health care cost growth, but population aging. Indeed, aging is responsible for over three fifths of the projected increase in Medicare spending through 2039, based on estimates from CBO.

⁶ <http://www.bloombergview.com/articles/2014-04-14/will-burwell-coral-health-care-costs>

Non-ACA Sources of Spending Growth (2014-2039)



Source: CRFB calculations based on CBO data
 Excess health cost growth is the extent to which health care costs per beneficiary, adjusted for demographic changes, grow faster than potential GDP per capita



And finally, the slowdown itself is highly uncertain. Just as businesses and families plan for uncertainty with precaution, so too should government. It is far better to overcorrect and be able to distribute the gains through more generous benefits or lower taxes later than it is to do nothing and let health care costs slip away from us.

It is also worth noting is that even under CBO's current law projections, federal health spending continues to grow as a share of GDP. Since 2000, federal health care spending has grown from 3 percent of GDP to 5 percent today, and it is projected to grow to 6 percent of GDP by 2025, 9 percent by 2050, and 13 percent by 2085.

The bottom line is that while the slowdown is very good news, it's far from enough to declare the problem solved.

- 15) Under the PREP plan you mention in your testimony, you would advocate for increased co-pays and changes to out of pocket limitations for some Medicare beneficiaries. How can you make these types of changes while still protecting those who are most in need?

In many ways, the current Medicare benefit fails to protect vulnerable seniors. Unlike most private insurance, the Medicare program has no out-of-pocket cap which means

that some seniors could face astronomical and completely unaffordable health care costs. To protect themselves against these costs, many seniors will buy supplemental coverage – but that coverage is often a really bad deal for seniors and can end up increasing average out of pocket costs by \$400 per year or more.

Our PREP Plan, like plans from Simpson-Bowles, Domenici-Rivlin, and others, would actually fix these problems. While seniors with low predictable costs would often face a modestly higher deductible, many of them would also face much lower premiums from supplemental coverage. More importantly, for the first time Medicare would have a catastrophic cap that limits senior costs from ever getting too high in a single year and could dramatically reduce the instance of medical bankruptcy.

Simply restructuring cost-sharing and supplemental coverage rules to focus more on catastrophic instead of first-dollar protections would be a huge win for vulnerable seniors by protecting them against the real financial risks associated with high medical bills. But to be safe, the PREP plan goes even further by offering a lower deductible and a lower out-of-pocket cap for beneficiaries with lower overall incomes.

16) Although our annual deficits have declined by about two-thirds since 2009, you argue that the long term debt will exceed the size of the economy sometime in the 2030s and will double the size of the economy between 2045 and 2080 as health and retirement spending continue to grow and revenues fail to keep up. What is the practical impact of that level of debt on the American people? Is this something the average American really needs to worry about?

Anyone that cares about future growth in the economy, interest rates on mortgages and other loans, or the well-being of their children and grandchildren should be concerned about the unsustainable nature of our national debt. Although it is true that deficits have declined by about two thirds from their “great-recession” high of \$1.4 trillion, that was after deficits had *risen by nearly 800 percent*. Moreover, deficits are likely to start rising again very soon, and CBO projects trillion dollar deficits will return by 2025 or sooner.

Unfortunately, even as deficits have subsided some, debt remains at record-high levels never before seen except around World War II. And due to population aging and health care cost growth, debt is scheduled to continue to grow unsustainably in the future.

As debt continues to grow, it will tend to push up interest rates, slow the growth of wages, reduce government's abilities to respond to new needs, and could ultimately cause a financial crisis.

As one example, Fix the Debt ran an analysis of how income would differ over the next few decades if debt were on an upward path as a share of GDP versus a downward path. Using numbers from the non-partisan Congressional Budget Office (CBO), we found that in today's dollars (adjusted for inflation), average income would be \$7,000 lower with debt rising by 2040 and \$13,000 lower by 2050. For someone entering the workforce today and earning average levels of income over his or her 40-year career, that represents a \$250,000 loss in income.⁷

As another example, Fix the Debt estimated the impact of a one-point difference in interest rates between those two scenarios, as calculated by CBO. That higher interest rate on government debt would end up trickling into small business loans, student loans, credit card loans, and mortgages. For a family with a \$300,000 mortgage, it could mean \$45,000 more in mortgage payments.⁸

With income lower and cost-of-living higher, there is no question that ordinary Americans will be hurt by the growing national debt. And unfortunately, those consequences would only be exacerbated by the reality that high debt will limit government's ability to respond to crises or address new important national needs.

Eventually, rising debt will become so unsustainable that the only possible ways forward will be severe austerity or a fiscal crisis. Needless to say, neither of these choices would be very appealing for the American people.

17) Seniors across the country rely on Medicare to meet their basic health care needs. What should we tell those folks back home that are worried about the need to make changes to the program? Should they be worried or concerned?

Herbert Stein once said that "If something cannot go on forever, it will stop." This certainly applies to the growth of federal health spending, which has already risen from 3 percent of GDP in 2000 to almost 5 percent today, and CBO projects will continue to rise to 7.5 percent by 2035 and 14 percent by 2090.

⁷ <http://www.fixthedebt.org/debt-and-you>

⁸ Ibid.

This trend is totally unsustainable. Sometime before 2030, it will result in the exhaustion of the Medicare Part A trust fund, leading to roughly a 15 percent across-the-board cut in that program. Meanwhile, the projected growth in other federal health spending programs simply can't be tolerated forever.

It doesn't just matter that this spending can't continue, it matters how it won't continue. Will there be exhausted trust funds, abrupt spending cuts, and major cost-shifts designed to quickly reduce the federal government's burden? Or will we proactively enact thoughtful reforms that can help change the way we consume and deliver medicine for the better?

Seniors stand to lose the most by waiting to act. The longer we delay reform, the more likely we are to see unnecessary cuts in the future. Meanwhile, there are changes we can make today which will actually *improve* the situation for seniors by reducing their out-of-pocket costs and improving their value of care.

Seniors shouldn't be worried about the reforms Congress wants to enact, they should be worried about the reforms Congress doesn't want to enact. Inaction is the deadliest treatment of all.

18) There was a lot of discussion on the first panel of the hearing regarding Medicare benefit modernization reforms. Can you discuss how cost-sharing reform can benefit both beneficiaries and Medicare?

A number of groups and individuals from a diverse set of backgrounds have called for modernizing Medicare's cost-sharing rules. Although each plan differs, they all focus on combining Medicare Part A and Medicare Part B into a single benefit, reducing the prevalence of wrap-around coverage, and shifting the nature of the Medicare insurance package so it focuses more on providing protection against catastrophic costs and less about covering regular expenses.

Because these plans would generally increase deductibles for seniors, many have described them as increasing seniors' cost. However, these plans don't really increase costs at all, but rather change the incidences of costs so that seniors are responsible for more of their low-cost known expenses and less responsible for high-cost care that could threaten to lead to medical bankruptcy.

And in fact, when one accounts for the savings from moving people away from costly Medigap plans, cost-sharing reform can significantly reduce total costs both for beneficiaries and the federal government.

As one example, our PREP Plan would reform cost-sharing rules by creating a combined \$600 deductible, a 20 percent co-insurance for most services, and a \$6,000 out of pocket limit for most seniors, with lower deductibles and out of pocket limits for seniors with more modest income. It would also restrict first-dollar coverage in “Medigap plans” (with a few years of grandfathering for existing plans) and encourage seniors to “cash out” their employer-provided wrap-around plans in exchange for a premium subsidy.

Even with phase-ins, these reforms would save the federal government \$80 billion over ten years. At the same time, according to an analysis from the Actuarial Research Corporations (ARC), this plan *would reduce average out of pocket costs by nearly \$225 per person each year*. In other words, the policy is a win-win for beneficiaries and the Medicare program.