

**Congress of the United States**  
**Washington, DC 20515**

January 9, 2015

Dr. Mark E. Miller  
Executive Director  
Medicare Payment Advisory Commission  
425 Eye Street, N.W., Suite 701  
Washington, D.C. 20001

Dear Dr. Miller:

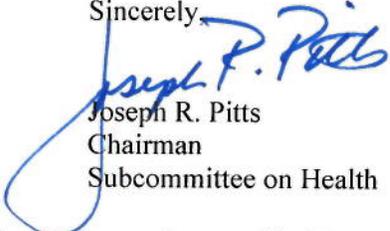
Thank you for appearing before the Subcommittee on Health on Tuesday, December 9, 2014, to testify at the hearing entitled "Setting Fiscal Priorities."

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

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business Monday, January 26, 2015. Your responses should be mailed to Adrianna Simonelli Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to [Adrianna.Simonelli@mail.house.gov](mailto:Adrianna.Simonelli@mail.house.gov).

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

Sincerely,

  
Joseph R. Pitts  
Chairman  
Subcommittee on Health

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

Attachment

## Attachment —Additional Questions for the Record

### The Honorable Joseph R. Pitts

1. Despite the efforts by the president's fiscal commission members and many members of Congress, today lawmakers have not reached a \$4 trillion, or even a \$2 trillion, debt reduction deal. In fact, our national debt is several trillions of dollars higher than it was in 2010. How urgent is the need for action by this Committee in the coming Congress to address our health care spending?
2. Medical education reform has been cited by numerous government entities and private stakeholders as something that can create efficiencies and help our country better address its workforce issues in areas such as primary care. What is MedPAC's position on the need for medical education reform?
3. Currently, under the Medicare program, hospitals are reimbursed for the deductibles and co-pays left unpaid by Medicare beneficiaries. This is known as "bad debt." This policy has no parallel in the private sector –or in any other federal health program. The president's Fiscal Commission recommended terminating this special subsidy. The president's FY2015 budget recommended phasing this out as well, estimating it would save taxpayers \$30 billion over a decade. Can you explain the reasons for scrapping this policy?
4. In its March 2013 report to the Congress, MedPAC stated that "Medicare's rising costs are projected to exhaust the Hospital Insurance trust fund and significantly burden taxpayers. The financial future of Medicare prompts us to look at payment policy and ask what can be done to develop, implement, and refine payment systems to reward quality and efficient use of resources." How important are reforms that change beneficiaries' incentives to the policy options that MedPAC has put forward?
5. The Medicare program pays a higher rate for many services if provided in a hospital outpatient department versus a physician's office. In your opinion, what are the behavioral effects of a payment system that creates disparity between provider payments based on location? For instance, has it helped fuel provider consolidation or encouraged pattern shifts in where care is being provided?
6. We have heard concerns about the Medicare RUC process – a committee driven by the American Medical Association that assists in valuing physician services. Some have argued that the RUC overvalues specialty care and undervalues primary care. Other data suggests that certain specialty care services are undervalued relative to primary care. I am curious as to whether MedPAC has done any work in this area? Do you or the commission have any thoughts on this topic?
7. There was a lot of discussion regarding Medicare benefit modernization reforms and their impact on beneficiaries and the program. You mentioned there is "some redistribution" as a result of the proposed benefit modernization reforms. Can you elaborate on the degree and scope of that redistribution? For example, based on MedPAC's analysis, are the beneficiaries who save money relatively younger or older? Can you also explain what low-income protections would be included in such reforms?
8. 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. Can you comment on to what degree this slowdown in the rate of growth might be a result of demographic changes as Baby Boomers come into the program? Does this relative slowdown ameliorate concerns about insolvency?

of the program or crowd out of the discretionary budget? Why should Congress be concerned about an *increase* in health care costs, and Medicare spending in particular?

9. Based on what is known now about “delivery system reforms” included in the ACA (ACOs, CMMI, etc.) do you believe these policies reduce the need to address Medicare’s crowd out of the discretionary budget or the program’s coming insolvency –which would jeopardize care for seniors that depend on the program?
10. One of the reasons given for *not* making changes to beneficiaries’ cost sharing or benefit design is that beneficiaries have “paid for” Medicare via their payroll taxes. Can you discuss the downsides of that view, as it relates to the proportion of dollars paid by payroll tax vs. benefits used by an average beneficiary?
11. Some suggest federal savings are achieved in benefit modernization proposals in one of two ways— either through decreased utilization, based on the barrier/disincentive created by increased cost sharing, or by cost-shifting to beneficiaries and third party payers. Some have cited an analysis done by the Kaiser Family Foundation suggesting between 50 percent and 71 percent of beneficiaries would pay more under the proposed benefit modernization plans. While the impact to individual beneficiaries would depend in part on their relative utilization of services (inpatient and outpatient), can you discuss the scope of potential increases that beneficiaries might experience, as well as protections for cost-sharing included in these reforms that could reduce concerns about shifting costs to an older, poorer, and less healthy Medicare population?

### **The Honorable Jan Schakowsky**

1. Under MedPAC's proposal to combine the Part A and B deductible and add an out-of-pocket cap, there appear to be winners and losers; some who will pay less and some who will pay more. What data, studies or analysis can you provide concerning the impact of this proposal on cost sharing for individual beneficiaries? In particular, which beneficiaries would pay less and which beneficiaries would pay more? What percent of beneficiaries in a given year would pay more and which would pay less?
2. In explaining the impact on beneficiaries of the redesign proposal, you testified that, over time, beneficiaries run a greater risk of entering the hospital, so, over time, more beneficiaries would be likely to benefit from a catastrophic cap. Given that any catastrophic cap would likely apply on an annual basis, and that in any given year for any given beneficiary, a hospitalization would be less likely than utilization of Part B services, did the Commission's analysis incorporate any data or assumptions about income, savings or other means with which beneficiaries might have to pay such expenses on an annual basis, and, over multiple years? In other words, if beneficiaries are paying more out of pocket for Part B services in the years during which they have no hospitalizations, might this offset any savings they might incur by paying less when they do require hospitalization? Have you done an analysis on the impacts on beneficiaries overtime? If so, could you please provide that analysis?
3. Did MedPAC consider options to mitigate the potential negative impact of a combined deductible, such as exempting physician visits from the deductible? If so, please describe your ideas.
4. In its March 2012 report on Medicare redesign, MedPAC suggests that private-sector innovations in benefit design should be considered when weighing options to restructure traditional Medicare benefits. Generally speaking, private market plans incorporate a prescription drug benefit together with outpatient and hospital benefits, unlike traditional Medicare where the prescription drug benefit is

only available through a stand-alone private option. Did MedPAC consider incorporating a publically administered prescription drug benefit as part of its Medicare redesign proposal? If no, why not?

5. Further explain what you mean by imposing 'clearer price signals' to beneficiaries by increasing Medigap premiums.
  
6. In your written testimony, you state that "research has shown that supplemental coverage can lead to beneficiaries using more discretionary services because they have no financial incentive to consider the value of a service before choosing it (pg. 11)." You go on to note that the Commission's 2012 recommendations concerning a benefit redesign package "give beneficiaries better protection against high OOP spending, which creating financial incentives for them to make better decisions about their use of discretionary care."
  - a. Can you provide evidence that shows how much care, if any, sought by beneficiaries with supplemental coverage is 'discretionary' versus medically necessary?
  - b. Can you provide examples of 'discretionary versus medically necessary care?
  - c. How does charging a higher premium for a Medigap policy – which is paid every month regardless of whether any services are utilized- incentivize someone to "make better decisions about their use of discretionary care" other than making such policies less affordable?
  - d. What are the average premium costs for Medigap policies currently? What do you expect to be the average premium costs under your proposal?
  - e. Under the Commission's benefit redesign recommendations, how are providers incentivized/treated concerning recommending and providing care that may or may not be medically necessary? In other words, what would deter providers from both recommending and prescribing 'discretionary' services?