RPTR HUMISTON

EDTR CRYSTAL

A PERMANENT SOLUTION TO THE SGR:

THE TIME IS NOW -- DAY 2

THURSDAY, JANUARY 22, 2015

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Barton, Murphy, Burgess, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Green, Schakowsky, Butterfield, Sarbanes, Matsui, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff Present: Clay Alspach, Chief Counsel, Health; Leighton

Brown, Press Assistant; Noelle Clemente, Press Secretary; Robert Horne, Professional Staff Member, Health; Tim Pataki, Professional Staff Member; Michelle Rosenberg, GAO Detailee, Health; Krista Rosenthall, Counsel to Chairman Emeritus; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Greg Watson, Staff Assistant; Ziky Ababiya, Minority Policy Analyst; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Ashley Jones, Minority Director, Outreach and Member Services; and Arielle Woronoff, Minority Health Counsel.

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

Mr. Pitts. Ladies and gentlemen, we have floor votes coming up, so we are going to get started. The subcommittee will now come to order.

Today is the second day of our 2-day hearing on the permanent solution to the SGR. Yesterday we heard from a distinguished panel of experts on SGR financing issues. Today we have a panel of interested stakeholders.

Before I do that, we have a UC request, and I ask for unanimous consent to include the following statements for today's hearing record from the American Academy of Family Physicians and the American Ambulance Association. Without an objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. We have on our second panel today six witnesses. Mr. Richard Umbdenstock, president and chief executive officer of the American Hospital Association. Dr. Geraldine O'Shea, first vice president of the American Osteopathic Association Board of Trustees. Dr. Alan Speir, the medical director of Cardiac Surgical Services for Inova Health System and the chair of the Workforce on the Health Policy, Reform, and Advocacy for the Society of Thoracic Surgeons. Dr. Ken Miller, board president of the American Association of Nurse Practitioners. Dr. Barbara McAneny, chair of the American Medical Association's Board of Trustees and CEO of the New Mexico Oncology Hematology Consultants; and Mr. Eric Schneidewind, president-elect of AARP.

Hope I didn't butcher your names too much. But thank you for coming today. Thank you for testifying. Your written statements will be made a part of the record. You will each be given 5 minutes to summarize your testimony, and your entire written statement will be made a part of the hearing record.

So we will begin with you, Mr. Umbdenstock. You are recognized for 5 minutes for your summary.

STATEMENTS OF RICHARD UMBDENSTOCK, PRESIDENT AND CEO, AMERICAN HOSPITAL ASSOCIATION; DR. GERALDINE O'SHEA, FIRST VICE PRESIDENT, AOA BOARD OF TRUSTEES, AND MEDICAL DIRECTOR, FOOTHILLS WOMEN'S MEDICAL CENTER IN CALIFORNIA; DR. ALAN SPEIR, MEDICAL DIRECTOR OF CARDIAC SURGICAL SERVICES FOR INOVA HEALTH SYSTEM, AND CHAIR, WORKFORCE ON HEALTH POLICY, REFORM, AND ADVOCACY, THE SOCIETY OF THORACIC SURGEONS; DR. KEN MILLER, BOARD PRESIDENT, AMERICAN ASSOCIATION OF NURSE PRACTITIONERS; DR. BARBARA MCANENY, CHAIR, AMA BOARD OF TRUSTEES, CEO, NEW MEXICO ONCOLOGY HEMATOLOGY CONSULTANTS LTD.; AND MR. ERIC SCHNEIDEWIND, PRESIDENT-ELECT, AARP

STATEMENT OF RICHARD UMBDENSTOCK

Mr. Umbdenstock. Thank you very much. Chairman Pitts, Ranking Member Green, and distinguished members of the subcommittee, on behalf of the Nation's hospitals, thank you very much for having me here today.

Ensuring that physicians receive adequate reimbursement is important for patients and hospitals, and we support permanently replacing the Medicare sustainable growth rate, or SGR. We commend the Members of the House and Senate committees of jurisdiction, which last year unveiled legislation to fix the recurring physician payment problem by repealing the SGR formula.

The bill, however, did not include suggestions on how to cover the costs of these proposals. The AHA cannot support any proposal to fix the physician payment problem at the expense of funding for services provided by other caregivers. Offsets should not come from other providers, including hospitals, who are themselves working to provide high quality, innovative, and efficient care to beneficiaries, but are already being paid less than the cost of providing these services. Congress needs to move away from this practice.

Market forces and significant reforms in both the public and private sectors are actively reshaping America's healthcare delivery system. In 2013, hospitals employed about a third of the Nation's physicians, and this number is growing rapidly. To reduce hospital payments to prevent physician cuts is therefore counterproductive and would adversely impact the very physicians Congress is trying to help.

Hospitals' ability to maintain the access to care their patients and communities expect is further threatened by repeated ratcheting down of payments for Medicare and Medicaid hospital services to pay for other priorities.

Recognizing that the AHA cannot simply oppose hospital payment cuts without supporting other solutions, we would like to highlight policy changes where Congress could both positively impact Medicare's finances and pay for a permanent SGR fix. Specifically, we recommend taking steps to promote and reward accountability and to use limited

healthcare dollars wisely.

Our recommendations are drawn from an AHA report entitled "Ensuring a Healthier Tomorrow: Actions to Strengthen Our Healthcare System and Our Nation's Finances," which is appended to my written statement. Our recommendations are similar to ideas that have received bipartisan support from a number of commissions, lawmakers, and the administration, and would not only generate savings, but also put the Medicare program on firmer financial footing for years to come.

First, modernize Medicare by combining Parts A and B with a unified deductible and coinsurance. Enrollees have conflicting incentives to weigh relative costs when choosing among options for treatment. Moreover, if Medicare patients incur extremely high medical costs, they can face a significant amount of cost sharing, because the program does not cap these expenses. This proposal would replace the current complicated mix of cost-sharing provisions with a single combined annual deductible covering all services in Parts A and B; a uniform coinsurance rate for amounts above that deductible, including the inpatient expenses; and an annual cap on each enrollee's total cost-sharing liabilities.

The administration also has proposed increased beneficiary cost sharing, such as increased Part B deductibles for new Medicare beneficiaries. The AHA agrees with the administration's position that Medicare cost sharing, quote, "helps to share responsibility for

payment of Medicare services between Medicare beneficiaries," and that increased cost sharing will serve to, quote, "strengthen program financing and encourage beneficiaries to seek high-value healthcare services."

Second, make modifications to first-dollar Medigap coverage. Some Medigap plans cover all or almost all copayments, including even modest copayments for routine care that most beneficiaries can afford. This practice gives beneficiaries less incentive to consider the cost of services, leading to higher Medicare utilization, costs, and Part B premiums. There are various proposals for improving incentives under Medigap. Specifics on the structure of first-dollar Medigap changes can be discussed and determined by the Congress, and the AHA is open to the administration's and CBO's proposals.

Third, increase income-related premiums under Medicare. The administration in its 2014 budget proposed doing this based on Medicare beneficiary income, and this is another approach the AHA believes Congress should explore.

And, fourth, reform the medical liability system. Hospitals and physicians continue to face skyrocketing costs for professional liability insurance.

In conclusion, there are many actions providers need to pursue, and we are working on those in areas of our control. For example, seeking to eliminate preventable infections and complications, as well

as eliminating nonvalue-added treatments. And we are making real progress. Study after study confirms that hospitals are improving the quality and equity of care they deliver. Just last week the CDC announced that hospitals reduced central line associated bloodstream infections and surgical site infections by 46 percent and 19 percent, respectively, between 2008 and 2013.

The AHA's Health Research and Educational Trust directed a national project to reduce central line infections and is currently administering a program and fellowship to prevent catheter-associated urinary tract infections, as well as directing the Nation's largest hospital engagement network.

All of this shows that real improvements in health and health care, not arbitrary cuts to provider payments, have the ability to put our country on a more sustainable fiscal path, and they have received bipartisan support.

We look forward to working with the committee to solve the Medicare SGR problem. Thank you very much.

Mr. Pitts. The chair thanks the gentleman for that very constructive testimony.

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

[The prepared statement of Mr. Umbdenstock follows:]

******** INSERT 1-1 ********

Mr. Pitts. Dr. O'Shea, you are recognized for 5 minutes.

STATEMENT OF GERALDINE O'SHEA

Dr. O'Shea. Chairman Pitts and Ranking Member Green, members of the subcommittee, on behalf of the American Osteopathic Association, thank you for the opportunity to testify today on the importance of permanently reforming the Medicare physician payment system.

My name is Geraldine O'Shea. I am a DO, I am a board certified osteopathic internist from Jackson, California. I have been practicing osteopathic medicine for 22 years. Osteopathic physicians, like M.D.s, are fully licensed to prescribe medicine and practice in all specialty areas, including surgery. DOs are trained to consider the health of the whole person and use their hands to help diagnose and treat their patients. DOs take care of people, not problems, and utilize a mind, body and spirit, patient-centered approach to healing itself. DOs use this approach in addition to all other modalities of modern medicine.

Over 60 percent of practicing DOs specialize in primary care fields. The profession also has a longstanding history of training physicians who practice in rural and other underserved areas. I am currently the medical director of Foothills Women's Medical Center in Jackson, California. My practice is comprised of women's health and

primary care and also hospital care, and I deliver it each day, and I have the opportunity to see and treat my patients. I also serve on the Board of Trustees for the American Osteopathic Association, which represents 110,000 osteopathic physicians and osteopathic medical students, who are training in 30 colleges of osteopathic medicine in 42 locations across our Nation.

Today I will share with you my personal experience of the detrimental impact the current Medicare physician payment system has on all physicians and how it is a barrier to high-quality care for our Nation's seniors. My charge here is not only to represent osteopathic physicians and medical students and our medical M.D. colleagues, but really to advocate for the patients that we serve.

Payment reform should no longer be an if, but must be a when, and the time is now. The current system is stifling innovation and preventing a move to a system focused on quality of care instead of volume. It is also stifling a move to delivery models focused on care coordination and a systems approach.

As a DO, this fragmentation does not align with my training and the philosophy behind osteopathic medicine. It is time we looked past short-term solutions. We must instead consider the Medicare system as a whole, physicians and other providers, and most importantly our seniors. The impact of inaction today or continuation of only treating the short-term problem will have negative repercussions for the health

of Medicare, and we must keep this in mind throughout today's discussions.

The osteopathic profession continues to fully support the bicameral, bipartisan policy framework that was developed last year by all three committees of relevant jurisdiction in Congress, and we thank you all here too. We greatly appreciated that the committees incorporated input from the physician communities at every step of the way and gained overwhelming support of the house of medicine, and that is not an easy task.

Quality of care will ultimately improve when payment incentives increase and are aligned with healthcare quality. The proposal would stabilize physician payments while transitioning into a system that promotes the delivery of high-quality patient care. The new system includes strong recognition of the importance of primary care as supported by the patient-centered medical home. The AOA was one of the four organizations which developed the principles of the medical home.

The proposal also works to align the current disjointed quality reporting programs to ease the administrative burdens placed upon physicians. This means we can spend less time with paperwork and more time with our patients, where we are needed most.

There have been various proposals advanced and discussed over the years by lawmakers and advocates on how to specifically pay for or even

not pay for a permanent fix to the SGR. However, we need to consider the whole system, just as the osteopathic physician considers the whole person in determining how an illness or issue might be impacting a patient.

Recent congressional discussions on other healthcare priorities have included strong consideration of unpaid legislative solutions, and these considerations should also be extended to payment reform. We must recognize there cannot be significant legislative action on other important healthcare priorities until the physician payment issue is permanently resolved. It is not for us as physicians to be prescriptive in which specific approach Congress should take in offsetting a permanent solution to a reformed Medicare physician payment system.

Whether targeted, unpaid, OCO, or a combination of these offset approaches, we urge Congress to consider the potential impact to the entire healthcare system, particularly on our patients. Jeopardizing patient access to care within the Medicare program cannot be an option. The AOA advocates for the patients we serve, including enhancing their access to care, to protecting the patient-physician relationship, because we believe this is vital to the delivery of quality health care.

As leaders of Congress, we do implore you to take action now, before March 31, to fix the physician payment system permanently, protect seniors, and strengthen the Medicare program.

I thank you for your time today. I am hopeful on this behalf of my physician colleagues and patients that this Congress will get this issue resolved permanently. And I thank you very much.

Mr. Pitts. We hope so. Thank you very much, Dr. O'Shea.

[The prepared statement of Dr. O'Shea follows:]

******** INSERT 1-2 ********

Mr. Pitts. Dr. Speir, you are recognized for 5 minutes for your opening statement.

STATEMENT OF ALAN SPEIR

Dr. Speir. Thank you. Good morning. Chairman Pitts, Ranking Member Green, and distinguished members, of the committee, thank you for the opportunity to present testimony today on behalf of the Society of Thoracic Surgeons. My name is Alan Speir, and I am a practicing cardiothoracic surgeon and medical director of Cardiac Surgical Services just across the river in the Inova Health System. I am also chair of the Workforce on Health Policy, Reform, and Advocacy for the Society of Thoracic Surgeons, and chair of the Board of Directors for the Virginia Cardiac Surgery Quality Initiative.

Founded in 1964, the STS is an international not-for-profit organization representing more than 6,800 surgeons, researchers, and allied healthcare professionals in 90 countries who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lung, and esophagus, and other surgical procedures within the chest.

On behalf of the Society, I would like to applaud this committee for holding a hearing on Medicare physician payment reform just 11 days into this new Congress. We are grateful for your sense of urgency and are eager to work with you to ensure that permanent SGR repeal and

Medicare payment reform are enacted this year.

I would also like to thank you for introducing the SGR Repeal and Medicare Provider Payment Modernization Act in the last Congress. I would implore you not to leave this major policy achievement to languish beyond the current March expiration of the current SGR patch.

I hope that my testimony today helps to demonstrate that the cost of continuing nothing will be far more devastating to Medicare patients and providers than the expense of implementing a meaningful payment reform policy.

In my written comments, I provide additional information on the STS National Cardiac Database and the Virginia Cardiac Surgery Quality Initiative, both of which provide a foundation for our remarks here today. Established in 1989, the fundamental principle underlying the STS National Database has been that surgeon engagement in the process of collecting information on every case, combined with robust risk adjustment based on pooled national data and feedback of such data to the individual practice and institution, will provide the most powerful mechanism to change and it will improve the practice of surgery for the benefit of our patients. For example, published results of patients undergoing coronary artery bypass surgery between 2000 and 2009 in institutions participating in the database realized a 24 percent reduction in mortality and a 26 percent reduction in perioperative stroke.

The VCSQI is a regional collaborative that is voluntary within the Commonwealth of Virginia, comprised of 14 cardiac surgical practices and 18 hospitals, founded in 1994 to improve the results of cardiac surgical care and to reduce cost. By creating evidence-based protocols using patients' clinical information, matched with administrative and cost data, the VCSQI demonstrated improving quality will reduce costs. For example, the VCSQI generated more than $43 million in savings to all payers through blood product conservation efforts, and more than $20 million in savings by identifying the best treatment for cardiac surgical patients with a perioperative arrhythmia called atrial fibrillation.

The STS has long advocated that claims information is critical to the effort to provide patient outcomes and care efficiencies. We are particularly grateful that the proposed SGR legislation would have allowed qualified clinical data registries to access Medicare administrative claims data. This legislation would also have provided a pathway for the development of specially driven alternative payment models that will allow payments and providers alike to benefit from quality and efficiency improvements.

Essential to that transition is a period of predictable payment for physicians without the threat of SGR-related cuts. It is this last point, the opportunity to develop alternative payment models during a so-called period of stability, where I would like to focus my

remaining comments.

Inspired by this in innovative proposal, the STS convened our thought leaders and policy and registry experts to examine the procedures most frequently performed by the STS. Together, we worked to craft team-based alternative payment models for the Heart Team and Lung Cancer Care Team in hopes that these models will provide a blueprint for other care team models in our specialty. We are confident that we can use the STS cardiac database, combined with administrative claims data and quality information from others in the care team, to promote patient-centered, team-based care that improves clinical outcomes and patient satisfaction, lowers healthcare costs, and rewards all providers by putting the patient first.

While our APM concepts are not yet finalized, I wanted to demonstrate to this committee that the physician community is ready and eager for this opportunity. Unfortunately, as we wait for payment reform to become a reality, the Centers for Medicare and Medicaid Services is implementing policy that will decimate the proposed period of stability, stifle innovation, and limit our ability to transition to new alternative payment models. Specifically, CMS proposes to convert more than 4,000 10- and 90-day global surgical CPT codes to a zero-day global by 2017 and 2018 respectively.

Currently, the cardiothoracic surgeons receive a single bundled payment from Medicare for the surgeries they perform. This payment

includes preoperative consultation, the operative procedure itself, perioperative and post-operative care, and coordination of medical specialty consultations and outpatient visits.

Mr. Pitts. If you can summarize, please.

Dr. Speir. Thank you.

It is clear that the Medicare payment reform is fatally flawed. Furthermore, with the uncertainty of the SGR paradigm, compounded by CMS global payments issues, innovation and meaningful physician-led reform is nearly impossible.

Mr. Pitts. Thank you very much, Dr. Speir.

[The prepared statement of Dr. Speir follows:]

******** INSERT 1-3 ********

Mr. Pitts. We are presently voting on the floor. We are still going to try to get a couple more of you in. So the chair recognizes Dr. Miller for 5 minutes.

STATEMENT OF KEN MILLER

Mr. Miller. Thank you, Chairman Pitts, Ranking Member Green, and members of the committee. I appreciate the opportunity to speak with you today on behalf of the American Association of Nurse Practitioners, the largest full-service professional membership organization for nurse practitioners of all specialties. With over 56,000 individual members and over 200 organization members, we represent the more than 205,000 nurse practitioners across the Nation.

My name is Ken Miller, and I currently serve as the president of the American Association of Nurse Practitioners. I am a family nurse practitioner, and previously served as the associate dean for academic administration at the Catholic University of America here in the District.

I am here to confirm our support of efforts to repeal the Medicare SGR, particularly SGR Repeal and Medicare Provider Payment Modernization Act of 2014 proposed in the last Congress.

As you know, nurse practitioners have been providing primary, acute, and specialty care for half a century and are rapidly becoming

the healthcare provider of choice for millions of Americans. According to our most recent survey data, more than 900 million visits were made to NPs in 2012, a number we anticipate will grow in the coming years. AANP strongly believes this serves as a testament to the trust that patients have in our workforce.

We commend the committee for their bipartisan legislative proposal, which recognizes all Part B providers, including nurse practitioners. Throughout the development of this legislation, the committee gave all stakeholders the opportunity to provide comments. This open process led to a strong bipartisan product, and this process should serve as a model as we move forward.

The legislation seeks to include all Medicare Part B providers by utilizing provider-neutral language. In addition, it includes a number of proposals that reflect the full partnership of nurse practitioners in the Medicare program, specifically the inclusion of nurse practitioners in the first year of the Merit-Based Incentive Payment System and ensuring that nurse practitioner-led Patient Centered Medical Homes are eligible to receive incentive payments for the management of patients with chronic disease.

Every day, increasing numbers of baby boomers become eligible for Medicare. Projections show that the number of beneficiaries are expected to increase by 20 million over the next 10 years, resulting in approximately 72 million patients being treated. Nurse

practitioners are ready to do their part to ensure these patients receive timely, high-quality care.

According to the American Association of Colleges of Nursing, there are currently 63,000 students enrolled in nurse practitioner programs in the United States, with over 16,000 students graduating in 2014. Nurse practitioners provide care in nearly every healthcare setting, including clinics, hospitals, emergency rooms, urgent care sites, private physician or NP practices, both managed and owned by NPs, nursing homes, schools, colleges, retail clinics, public health departments, nurse-managed clinics, and homeless clinics. It is important to remember that in many of these settings, nurse practitioners are the lead provider.

Nurse practitioners have continuously played a key role in treating Medicare beneficiaries, and since 1998 NPs have received direct reimbursement for providing Medicare Part B services in all settings. Nearly 85 percent of the current workforce are treating Medicare beneficiaries. Additionally, Medicare data shows that almost 17 percent of the beneficiaries in traditional fee-for-service coverage receive one or more services every year from NPs that bill Medicare directly.

The vast majority of NPs are primary care providers. Eighty-eight percent are educationally prepared to be primary care providers, and over 75 percent currently practice in primary care

settings. NPs bring a comprehensive perspective to health care by blending clinical experience in diagnosing and treating acute and chronic illnesses with an added emphasis on health promotion and disease preventions.

This comprehensive perspective is deeply rooted in nurse practitioner education. All NPs must complete a master's or doctoral program and have advanced clinical training beyond their initial professional registered nurse preparation. Didactic and clinical courses prepare them with specialized knowledge and clinical competency to practice in a variety of settings.

Daily practice includes assessment, ordering, performing, supervising, and interpreting diagnostic and laboratory tests, making diagnoses, initiating and managing treatment, including prescribing medication, as well as nonpharmacologic treatments, coordination of care, counseling, educating patients, their families, and communities.

In closing, the American Association of Nurse Practitioners would like to reiterate its support for the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 proposed in the last Congress. AANP is ready to provide support throughout the legislative process in the 114th Congress and looks forward to working with the committee and this Congress on the passage of this bill in 2015. Thank you.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Mr. Miller follows:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

******** INSERT 1-4 ********

Mr. Pitts. Dr. McAneny, you are recognized for 5 minutes.

STATEMENT OF BARBARA MCANENY

Dr. McAneny. Thank you, Chairman Pitts and Ranking Member Green, members of the committee. My name is Barbara McAneny, and I am an oncologist from Albuquerque, New Mexico, and I am chair of the American Medical Association Board of Trustees.

The AMA believes that the Medicare sustainable growth rate formula, the SGR, presents one of the most important yet difficult challenges our healthcare system faces today. We commend this committee for its extensive work in the last Congress and for taking this first step in the 114th Congress to resolve this issue.

The time is ripe for Congress to finish the task of repealing the SGR and replace it with payment reforms that enhance and support patient care. Congress should act quickly to enact the SGR Repeal and Medicare Provider Payment Modernization Act reported by this committee in the 113th Congress by a vote of 51 to 0 as part of a thoughtful, bipartisan, and bicameral process.

This legislation represents an end to the fundamentally flawed SGR formula, which is a major barrier to the development and adoption of healthcare payment and delivery reforms that can improve the care for our Nation's seniors and the disabled while reducing overall

spending. Also, TRICARE is tied to Medicare payments, so our Nation's military and their families will also benefit from its passage.

The reforms included in this legislation enjoy the strong support of an array of stakeholders, including over 600 State, specialty and national medical associations, as well as organizations representing the interest of patients.

Under this proposal, physicians who join new payment models would be supported in their transition into new models of care delivery that would improve the quality and deliver more coordinated care while saving the Medicare system money. There are now 424 accountable care organizations serving over 7.8 million Medicare beneficiaries, and this has saved Medicare $417 million. The committee proposal would expand our ability as physicians to develop and participate in even more innovative ideas.

Right now physicians are facing a tsunami of penalties from the various Medicare quality reporting programs: PQRS, Meaningful Use, and the Value-Based Payment Modifier. Under the committee proposal, we would report under one streamlined program known as the Merit-Based Incentive Payment System, or MIPS. We would no longer be forced to divert our attention and our resources towards complying with overlapping and often conflicting programs. Instead, we could focus those resources on making meaningful changes in our practices that benefit our patients.

We need the flexibility that the MIPS program provides so that we would be free to demonstrate our quality of care according to the standards that match our specialty and our type of practice. Therefore, the committee proposal does far more than merely replacing the SGR, it is an important step forward to help physicians to successfully restructure our practices to provide better care at a lower cost.

Please take this opportunity to build upon the progress that your committee has already made by continuing to work in a bipartisan manner to resolve the remaining barriers to these significant policy reforms.

Everyone agrees that we need to contain Medicare spending, but the SGR was never the solution and it simply has not worked. The 17 SGR patches enacted since 2003 have cost the Federal Government over $169 billion, which is far more than the CBO's estimate of this committee's proposal. So the time to replace the SGR is now.

We understand that the pathway forward must have the necessary bipartisan support to pass both chambers and to be signed into law by the President. Almost 10 months have passed since Congress set the latest deadline to enact the legislation, and time is running short. We urge this committee to commence negotiations to resolve these remaining questions. Only Congress can find the common ground to resolve the outstanding budgetary issues.

We are very appreciative of the committee's leadership on

Medicare physician payment reform, and the AMA stands ready to be a constructive partner. We thank you very much for the opportunity to share our views.

Mr. Pitts. Thank you very much.

[The prepared statement of Dr. McAneny follows:]

******** INSERT 1-5 ********

Mr. Pitts. We have got 1 minute left in the vote. We still have 260 people not voting. We will try the last one. So, Dr. Schneidewind, you are recognized for 5 minutes.

STATEMENT OF ERIC SCHNEIDEWIND

Mr. Schneidewind. Chairman Pitts, Ranking Member Green, and members of the committee, thank you for holding this hearing on reforming Medicare physician reimbursement and for inviting AARP to speak from the Medicare beneficiary's perspective.

My name is Eric Schneidewind and I am the AARP president-elect. AARP is a nonpartisan organization of over 38 million members ages 50-plus, many of whom are Medicare beneficiaries. During the previous Congress, AARP was pleased to work with committee staff from both chambers and both parties in developing what became H.R. 4015.

Permanently repealing the sustainable growth rate formula will bring stability and predictability to healthcare providers and Medicare beneficiaries. The reimbursement reforms in the bicameral bill are a significant step toward improving quality and value. We applaud the move toward more coordinated care, the streamlined quality measurement and reporting system, and greater data transparency. Thanks to the tireless work of many of the legislators and staff here today, we are closer than we have ever been to finally replacing this

broken reimbursement system.

However, the final bill introduced last Congress did not include important health extenders, which are usually included with the annual doc fix legislation. Three provisions in particular are crucial and should be made permanent along with permanent SGR repeal legislation.

First, the Qualifying Individual -- QI -- Program pays Part B premiums for beneficiaries with incomes between 120 percent and 135 percent of the federal poverty line. Most Medicare beneficiaries pay a monthly Part B premium of $104.90 and out-of-pocket costs that low-income QI recipients cannot afford.

Second, the Medicare therapy caps exception process allows access to needed care for people with long-term chronic conditions, most notably for those who require long-term therapy services.

Third, funding for critical community-based resources is also expiring. This includes outreach and enrollment assistance to low-income Medicare beneficiaries, as well as funding aging and disability resource centers. AARP will not consider SGR repeal legislation complete unless those beneficiary protections are included.

However, a question still remains on the need for budget offsets. In light of current and future savings in the Medicare program, Congress would be justified in not fully offsetting the costs of a permanent repeal at this time.

As the committee considers legislation, it is important to remember that half of all Medicare beneficiaries live on an income of less than $23,500 per year and spend 17 percent of their income on health care. Additionally, standard beneficiary premiums are established to cover 25 percent of Part B spending. Given this, one-quarter of any increase in Medicare Part B spending over current law will automatically be borne by beneficiaries in the form of higher premiums. The typical Medicare beneficiary cannot afford to pay more out of pocket.

AARP has long advocated for responsible solutions for slowing Medicare spending growth and improving the program. Other system reforms recommended by AARP to help reduce Medicare spending, not part of H.R. 4015, include expanding competitive bidding for durable medical equipment, equalizing payments based on physician site of service, recouping overpayments to Medicare Advantage plans, increasing support for transitional care and chronic care management, and ensuring full and effective use of all highly skilled clinicians.

In addition, while lawmakers have considered shifting cost to beneficiaries, there has been little talk of reforming one of the most expensive areas of health care, prescription drugs. AARP believes that any discussion of budget offsets for Medicare reimbursement reform should include savings from prescription drugs.

We urge you to give strong consideration to the following

prescription drug proposals that could save at least $150 billion: provide the Medicare program rebates for drugs for those who are dually eligible; enable the Secretary of HHS to negotiate for lower prescription drug prices; reduce the exclusivity period for biologic drugs; prohibit pay-for-delay agreements; and stop risk evaluation and mitigation strategies from being used to block generic drug and biosimilar product development.

Again, thank you for holding this hearing and for making SGR and Medicare reimbursement a priority at the start of the 114th Congress. AARP welcomes the progress that has already been made and looks forward to working with you to get physician payment reform across the finish line. I would be happy to answer any questions.

Mr. Pitts. Thank you for your testimony.

[The prepared statement of Mr. Schneidewind follows:]

******** INSERT 1-6 ********

Mr. Pitts. Time has expired on the vote. We have two votes on the floor, so members should go directly to the floor. Please come back immediately.

Thank you for your patience. The committee stands in recess.

[Recess.]

RPTR YORK

EDTR CRYSTAL

[11:06 a.m.]

Mr. Guthrie. [Presiding.] Thank you. We will bring the committee back to order. Thanks for your patience during our voting time. I guess we will have until 12:30 until the next set of votes, so hopefully we can get through the questions. And I will recognize myself for questioning.

Yesterday we had a first panel in the subcommittee, and we heard from members of both sides of the aisle who said that SGR reform must be paid for. Former Senator Joe Lieberman warned that stakeholders who are pushing for unpaid SGR reform bill could actually sink the chances of getting a permanent fix adopted by Congress. We also heard from policy experts that there are bipartisan improvements to Medicare which can help pay for SGR reform.

So I want to ask the panel, everybody, to answer to this question. So I would be curious in hearing very briefly from each of our witnesses the answer to this question: Would you rather see a permanent SGR fix pass in March with bipartisan pay-fors or see Congress be forced to do another patch? So pay-for or patch? The option really isn't a question to say, well, an unpaid-for fix. It is a paid-for fix or a patch. And let's go briefly down the line of witnesses.

Dr. Umbdenstock. Well, at the AHA, we would pick door number one. We think it needs to be fixed, frankly, should have been fixed a long time ago when the costs were lower, the problem was smaller. We put it off. At the moment, the rate of increase is so low that the projections are much lower as to the costs going forward. We think it should be taken care of, but I have to understand score again, not at the expense of payments to other providers.

Mr. Guthrie. Okay. Thanks.

Dr. Umbdenstock. We have got to find other solutions.

Mr. Guthrie. I am going to try to get down the list.

Dr. O'Shea.

Dr. O'Shea. As I said before, we know that it is not just for physicians to say, but we do know that offsetting needs to be done for a permanent solution. So we are actually for a permanent solution and not for a patch. A physician is never going to want a patch.

Mr. Guthrie. Thanks.

Dr. Speir.

Dr. Speir. Permanent fix.

Mr. Guthrie. Permanent fix.

Dr. Miller.

Mr. Miller. Permanent fix. We go with door one because the patch hasn't worked for so many years. We need to fix it.

Mr. Guthrie. Okay. Thanks.

Dr. McAneny.

Dr. McAneny. We also want a permanent fix to this. We are so close. You have developed great policy. If we can get the SGR out of the way, then we can move forward towards the more important work of trying to restructure how we actually deliver care to our patients.

Mr. Guthrie. Thank you.

Mr. Schneidewind.

Mr. Schneidewind. AARP would support a permanent fix, and we have proposed means to pay for it.

Mr. Guthrie. Okay. Thank you. Thank you very much.

For Mr. Umbdenstock from AHA, in your testimony you wrote down four different ideas you said for cutting funding. You expressed opposition to cutting funding for services provided by other caregivers, which you just reinforced, and I understand, and you suggested there is a tipping point of the repeated ratcheting down of payments for Medicare and Medicaid hospital services past which patients on these programs will face harder times or they will have longer wait times if we continue to go down.

Could you just describe for the committee the scope of the cuts the hospitals have seen since 2010 and what type of cuts in the way of market basket adjustments are on the horizon? The situation the hospitals have been in since 2010.

Dr. Umbdenstock. Be happy to. Thank you.

Since 2010, hospitals have experienced $121 billion in the 10 years after each of those cuts, $121 billion cumulative in cuts through the Medicare program, whether it was through sequestration cuts or cuts through coding offsets or reductions in bad debt payments under Medicare. A variety of different cuts have occurred totaling $121 billion.

In addition, there are payment reductions in the ACA that were agreed to, to help pay for coverage under the ACA. Those cuts are now starting to kick in as well. They were not in the first couple of years. They started essentially just before coverage started and now will roll out in the later years. So market basket adjustments, reductions in DSH payments, disproportionate share payments, and so on are almost looming. So additional cuts on top of that would be untenable.

Mr. Guthrie. You had several policy proposals when you did your testimony. Which ones that you brought forth would you suggest should be paired with SGR reform?

Dr. Umbdenstock. Well, those are four that we wanted to highlight, in particular the combining of Parts A and B and the restructuring of that outdated method under Medicare; modifying the first-dollar coverage in Medigap policies to make more prudent buyers within the Medicare program; and increase income-related premiums, med mal reform; and I didn't mention, but always on our list is administrative simplification and regulatory relief.

So we think that those have all been scored. They have all received bipartisan support and should be considered as pay-fors.

Mr. Guthrie. Thank you.

And I will yield back 5 seconds because we are going to try to get everybody in before the next round of votes, if we can stick to the 5-minutes rule as close as we can.

Mr. Green.

Mr. Green. Thank you, Mr. Chairman.

And I talked to some of you beforehand. You know, all of us want to repeal the SGR. It is the issue of paying for it and how do we pay for it. I don't want to put it on the backs of the Medicare patients. And some of you know the kind of district I represent. It is a very urban area. We have a great medical center in Houston. Although I have a very urban area, and the physicians who practice in my area are the ones 45 percent or 55 percent of their practice is senior citizens with Medicare. If we don't fix the SGR, they can't be in business.

Now, my suburban physicians can because they have a lot of third-party coverage, whereas if with you have a load of seniors on Medicare, you can't. So that is why I want to fix it, because I want those doctors to still be in my district so people don't have to go to the suburbs to see a physician. But that is the problem with paying for it.

Dr. McAneny, I understand the cost of a permanent repeal of SGR

is $118.9 billion. I think that is the cheapest number I have seen since we have had it. It would cost $32 billion just to fix it for 2 years. And one of our concerns is, and I have heard all your and read all your testimony, is that how do we do it without impacting the patients who are part of Medicare, because, as we know, seniors on Medicare pay a huge percentage higher for health care, even though they have Medicare, than seniors under 65.

And so that is our concern. Are there any suggestions? I know there are some reforms we can do, and the reforms may be good in idea, but if they save money, then we can use that as a pay-for.

Dr. McAneny. The AMA has a large body of Medicare reform policy which we have carefully thought of over many years and would love to have the opportunity to go over. With any pay-for, the question really will be in the detail. We feel that any solution is going to have to be bipartisan. It is going to have to be something that is bicameral and can be signed by the President. And we really look a lot to the leadership of this committee and Congress to lay the guidelines, and then we would be happy to work with you any way we can to try to look over the ideas that are presented.

We do believe that by getting the SGR out of the way and letting physicians restructure their practices, that we can do a lot to save money going forward. In my own practice, we have an Innovation Center grant that has created an oncology medical home. We have cut

hospitalizations for cancer patients by almost half. That saves money and it takes better care of our patients. So we think there are a lot of things out there that can really provide better care with lower costs and that that should be considered as part of the equation.

Mr. Green. Thank you.

Dr. Schneidewind, I know representing AARP, and your constituents are actually the Medicare recipients. Do you know if any of the health reforms that you have seen or heard today that would actually save enough money we could use it for a pay-for, but would also have more efficient delivery to your constituents, AARP members?

Mr. Schneidewind. Well, I think embedded in the legislation itself, of course, are reimbursement reforms which are going to produce that result. And I think what we look to is reforms that impact, for instance, competitive bidding for durable medical equipment. In one 5-year period there were $70 billion of overpayments to Medicare Advantage plans, we believe for upcoding and that sort of thing. So that would offer $140 billion over a 10-year period. Transitional care, we could support that better, and that obviously reduces readmission rates.

But really the place to look for the savings, we think, are the drug costs, and steps like extending the rebates from just Medicaid to dual eligibles, you are talking about $140 billion over a 10-year period from that one alone. So we really respectfully suggest that

this committee look hard at prescription drug costs as a place to save money, to leave these providers in a good position, and to make this Medicare program solvent and sound for the future.

Mr. Green. And I appreciate that because, again, in a district like I have, we have a lot of dual eligibles already. But that is the issue.

And, Mr. Chairman, I will yield back my 17 seconds.

Mr. Guthrie. Thank you. Being efficient. Trying to get the votes.

The next is also from Texas, Dr. Burgess.

Mr. Burgess. Thank you, Mr. Vice Chair. I appreciate you not referring to me as the old vice chair.

In the interest of time, I would like to actually pose a multipart question, or two questions, and then I would like to go down the line, starting with Rich and ending up at the AARP. And the two questions would be, as you understand the policy language of the 4015 in the previous Congress, are you supportive of that policy? And the second part to that question, would you support the committee making this a priority for this Congress? And not to lead the witnesses, but the correct answers are yes and yes.

Dr. Umbdenstock. Thank you for that clarification. Yes and yes.

Dr. O'Shea. Dr. Burgess, number one, we really want to thank you

for all the work that you have done, we appreciate it, as the physician leader that you are.

Yes and yes.

Dr. Speir. Thank you, Dr. Burgess. Yes and yes.

Mr. Miller. Thank you, Dr. Burgess. Yes and yes.

Dr. McAneny. To be redundant, thank you, Dr. Burgess. Yes and yes.

Mr. Schneidewind. Yes and yes. Thank you, Dr. Burgess.

Mr. Burgess. Great. I am glad we all got that on the record.

Dr. McAneny, I need to ask you a question. I may have to move to get to a right microphone.

We have talked about the SGR for a long time. I have had a bill every term I have been in Congress. But a lot of people don't really understand what happens if we blow through a deadline, which we did at the end of 2005 when Republicans were in charge and we did three times in 2010 when the Democrats were in charge. Can you kind of trace out for us what the effect is on a physician's practice and a patient's access to their physician when we blow through those deadlines and why it is so critical that we not face those deadlines year in and year out?

Dr. McAneny. Thank you, Dr. Burgess, for that question.

I do manage my practice in Albuquerque and in little towns in New Mexico where we serve a lot of underserved people. What happens when

we blow through one of those deadlines is that we suddenly cannot submit a bill. Our cash flow drops very quickly because not only do I have to make pay payroll every 2 weeks because my employees live on that, they have to pay their mortgages and buy food, but I cannot buy the supplies that I need to treat my patients. I cannot afford to purchase the chemotherapy to give to the patients who are in need of it.

Then we incur double damage in that when we submit a bill and then there is a patch or a change that occurs later, then we have to resubmit the bill. The accounting nightmares are terrible to try to figure out what has actually been paid, what still is owed. I often have had to take out bank loans or lines of credit, which means that we lose the interest on that. And I am a small business, we have 200 employees, and a lot of people depend on us for their livelihoods. So this really is a devastating idea.

And as we are trying to restructure what we do to provide better health care, the uncertainty of not knowing whether or not my major payer, Medicare, is going to be there, is going to cut my fees by 21 percent, or whether they are going to reinstitute a zero percent, which is actually a 3 percent loss because the expense goes up about 3 percent per year, I haven't been able to give my nurses and my staff a raise for the last 2 years.

So it is devastating to us as small businesses. It is devastating to us as physicians because we can't do what we were trained to do,

which is to take care of the people who depend on us.

Mr. Burgess. Well, and the reason I asked that question, of course, we have until March 31 for something to happen, which is get the President to sign the SGR fix or come up with a doc fix for whatever period of time, and I am concerned that if we spend too much time reinventing the wheel now we will burn through that daylight that is available to us and push up against the deadline.

But let me just ask you as a practical matter, and perhaps, Dr. O'Shea, you as well, are you talking with your constituencies, your doctors who are part of your association, about the possibility that the full SGR cut might happen, that if Congress couldn't get its work done, that you might face this funding cliff that is set out in the statute?

Dr. McAneny. Dr. Burgess, I think every physician, particularly those who manage a practice, considers that at about 3 in the morning, on a lot of mornings, of how am I going to keep the practice going if this happens. Yes, I think most physicians are aware that this would be devastating, and I think that more and more patients are becoming aware of what it would do to us if they couldn't get in to see their doctor at the time when they need their doctor.

Mr. Burgess. Thank you.

Dr. O'Shea. And I might say just, Dr. Burgess, say the same thing.

Mr. Guthrie. Well, the time has expired. We are trying to get everybody's questions before the next vote. So I appreciate that.

Ms. Matsui from California is recognized.

Ms. Matsui. Thank you so much, Mr. Chairman.

First of all, thank you very much for being here. Appreciate your testimony. It is a very important issue. And I know how much SGR repeal and replace means to each of your organizations.

I have a huge healthcare sector in my district, four major hospital systems. I think Dr. O'Shea knows because you are a member of one of them essentially. But I think that we have to do this. The thing is, the pay-for is so difficult. Where we stand now is seeing how to figure that out, and what I am hearing a lot about today is we want to do this but we don't want to do it here or here or here. And I am not singling anyone out, but that is the way it is here. But what I am looking at is let's do this but not at the expense of the seniors. Now, I think each of us feel that way too and are trying to balance that out.

So what I am looking at now is, let's be very specific, so some of these are questions I am hearing, currently Medicare beneficiaries have separate cost-sharing structures, when they see doctors versus when they go to the hospitals. There may be ways to simplify this and modernize Medicare benefits to look more like health insurance products we see today. But current proposals to redesign Medicare benefits such

as combining Part A and B deductibles would redistribute the burden of healthcare costs to the most vulnerable in the program.

So, Mr. Schneidewind, can you talk about the potential impact on beneficiaries of a combined Part A and B deductible?

Mr. Schneidewind. Yes, Representative. The Part A deductible is significantly higher than the Part B deductible, and so if those two are combined into one average number, it is pretty clear that a senior going for medical services as opposed to hospital would end up paying a higher deductible than they had prior to the change.

And what concerns us is that in that situation somebody who is using medical services a lot and hospital very little would effectively, number one, be penalized financially and have a disincentive to seek care from physicians. And I hope people will recognize that the average person who is receiving Medicare has an income of $23,500, half have less than that, they pay $4,000 out of that $23,500 for medical care already. So increasing that, in addition to the regular Part B increases that occur, is unaffordable.

Ms. Matsui. Okay. Thank you.

Now, these new payment delivery models incentivize and the SGR repeal and replace policy can make Medicare services more effective and maybe more efficient. This will save money while improving care. However, these savings are often difficult to demonstrate and quantify, as they occur in long-term time windows, we know how difficult it is

to even score those things, and involve savings to the overall health system, not to mention the improvement in quality care that can be an invaluable effect on a patient's life. You can measure and estimate the reduced hospitalization costs caused by better management of a senior's chronic conditions, but you can't put a price on how that impacts seniors and their caregivers' lives. So I believe a more holistic approach to patient care, including strong preventive care, saves costs and lives.

So, Dr. O'Shea, please discuss the benefits of the holistic approach to care, and include any comments you may have about savings that can be achieved and how this fits into what we are trying to do today, because I think we have to apply a holistic approach to this SGR replace-and-repeal policy too.

Dr. O'Shea. I appreciate the question.

Taking a holistic approach is what I think we have been gearing up for, for many, many years here. So what I would be speaking of is implementations the greater part of physicians around the country have done is with an her. The her and the patient-centered medical home are just ready to do these things, taking the whole patient into consideration. I actually lead the diabetic program at Sutter Amador Hospital.

Mr. Collins. Could you speak into the microphone?

Dr. O'Shea. As doing that, and as working with the chronic care

model, when you have more implementation of preventative services early on in the chronic care model, you are going to get larger savings, you are stopping the fast creep of a chronic and a high-cost patient into a much more controlled, extending the care in an ambulatory setting and not having to use the hospital setting.

We can do that, and I would speak also for combining Part A and B, if that can be achieved, but doing that and making sure that the primary care home that is specific for the patient, because it has to meet patient needs, is implemented, and in doing that in an aggregated affront to these costs, making the patient, but also the physician, accountable and knowing with all the information that we now can look at ourselves and look at your own cost savings, making those numbers known to physicians, to physician societies, to different state societies. You know, looking and then comparing to one another. I think as physicians we are used to being compared in services and things like that. You will actually find that we can tolerate that, can get geared toward that a lot faster than just always rotating patients.

Ms. Matsui. Okay. Well, thank you very much.

Mr. Guthrie. Thank you. The gentlelady's time has expired.

The chair is going to recognize for unanimous consent a standard of care statement that has been offered by the Cooperative of American Physicians, NORCAL Mutual Insurance Company, PIAA, Texas Medical Liability Trust, The Doctors Company. Without objection, so ordered.

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Guthrie. The chair now recognizes Chairman Barton.

Mr. Barton. Thank you, Mr. Chairman. It is good to see you in the chair. It is good to see Mr. Green as the ranking member of the Health Subcommittee. That is quite an honor. It is good to have you there.

I haven't watched this on TV, nor have I read your testimony. So I am a total innocent. But I will make a bet right now that we have agreement that we need to fix the SGR, everybody has said that, but I bet not one of the panelists has offered a way to pay for it. Am I right or wrong?

Voices. Wrong.

Mr. Barton. What? We had somebody offer a pay-for?

Dr. Umbdenstock. I think the American Hospital Association put forward suggestions, as did --

Mr. Schneidewind. As did AARP.

Mr. Barton. Well, I would have lost that bet. You all should have taken me up on it. I would have bought everybody a free Dr. Pepper down in my office.

Well, good for you. I was going to offer a proposed solution that the people that didn't testify had to pay for it, since you all weren't willing to pay for it.

So do we have an agreement that there should be a pay-for? Is there anybody that opposes that?

Mr. Schneidewind. We have raised the possibility that, given the reforms, there may not need to be, but out of respect for your desire for some information, we have proposed pay-fors.

Mr. Barton. Then the second part of is there a pay-for, I am going to ask the chairman if as a committee do we have a position that the pay-for should come out of the medical system or are we looking at pay-fors outside the medical system?

Mr. Guthrie. From what I understand, we are still looking at pay-fors. There has been no overall --

Mr. Barton. Within the medical --

Mr. Guthrie. I think we are looking at all pay-fors, all opportunities for pay-fors.

Mr. Barton. Okay. Because if we were willing to look outside the system we could do some oil and gas revenue royalties from the OCS or Alaska or federal lands. I have an Internet poker bill that would probably generate $50 billion over 10 years.

Mr. Green. If the gentleman would yield.

Mr. Barton. I would be happy to.

Mr. Green. Our side, we don't mind looking outside health care, but I have to admit, I can't sign on to your Internet poker bill.

Mr. Barton. That would be the easiest pay-for because the poker players of America would willingly pay that surcharge to be able to play poker on the Internet. And that was seriously looked at in the

last Congress, actually. I mean, it is enough money that it is real.

Well, I want to commend Dr. Burgess for the work that he has done over the last several years. He has been absolutely committed to fixing the problem. And as you all know, this last Congress we actually passed an SGR fix but we didn't have a pay-for and it foundered.

I think Chairman Upton and Subcommittee Chairman Pitts are committed to going all the way this session with a real pay-for that solves the problem, and I will be a part of it, of the system at that point in time.

With that, Mr. Chairman, I will yield to any other member who wishes my time.

Dr. Burgess.

Mr. Burgess. If the gentleman will yield for clarification. The bill that passed the floor of the House the middle of March of 2014 was paid for, was offset. The offset came from the Affordable Care Act. And for people who disagree with that strategy, I would simply offer that if you were going to reform health care in this country from soup to nuts, you ought to start by fixing the SGR. So that was a logical place to go. I am sorry people didn't agree with that over on the Senate side. I am willing to look at other pay-fors. But our bill was offset when it passed the floor of the House last March. And I yield back to the gentleman.

Mr. Barton. I guess I will ask one more question. Does the panel

think there are enough savings in Medicaid if we gave more flexibility to the States? All the State Governors and Medicaid directors are always asking us to give them more flexibility. Is that a potential pay-for that you all might be willing to work with us on?

Dr. Umbdenstock. Well, from the hospital point of view, we find Medicaid to be a very stressed program already and are very concerned about further cuts to that program.

Mr. Barton. So that is a no.

Dr. Umbdenstock. For the record, if you decided to solve this problem without a pay-for, we would not object. Just for the record.

Mr. Barton. Put me down as not surprised with that answer.

With that, Mr. Chairman, I yield back.

Mr. Guthrie. Thank you. The gentleman yields back.

Recognize Mr. Schrader from Oregon.

Mr. Schrader. Thank you, Mr. Chairman, appreciate it.

I appreciate the panel. I appreciate the panel for the most part coming up with ideas for us to pay for the SGR reforms, since it has such broad support to get this done and get the Sword of Damocles off the physician and hospital community's backs, and, frankly, the seniors, seniors' backs. They have been up against. I think every one of us has had horror stories of seniors not being able to find physicians or nurse practitioners to take care of them because of what we are doing or not doing here.

With that, just several questions. Dr. McAneny, maybe you could elaborate a little bit more on how the fee-for-service system is actually hurting or prohibiting -- not prohibiting, but I think impairing physicians' and nurse practitioners' ability to provide the quality care that they think they can do. You alluded to that a little bit.

Dr. McAneny. Thank you, Representative, for that question.

The fee-for-service system worked well before there was much that we could do in the outpatient arena. There were limited things we could. It was easy to enact fees for those. Currently, now, if we want to manage patients in a different way, if we want to have nurses or other staff members on the phone talking to patients, intervening early, helping people manage problems at home, we are not paid for that. And physician practices find that they have to generate enough of the billable codes to pay the infrastructure that it diverts our attention away from some of the changes that we could make to better deliver that care.

In addition, now with all the regulatory requirements that are there that are not paid for with trying to comply with Meaningful Use, PQRS, the value-based purchasing, et cetera, we are spending more and more time away from patients, away from anything that even generates a fee, and away from things that actually help us manage a patient. That is why we are so excited about this committee's proposed bill where

you get rid of all that, consolidate it into one streamlined system so that we can take some of those resources, have the opportunity to try out systems that may include some fee-for-service but may include a lot of other options as well, and see if we can't design systems that will work in our individual practices to be able to deliver better patient care at a lower cost. So thank you.

Mr. Schrader. Very good.

Dr. Speir, maybe describe a little bit how comparative effectiveness research can improve care and provide, hopefully, physicians, particularly in the specialities, almost a safe haven in terms of liability and lawsuit issues.

Dr. Speir. Thank you, sir. I think that we have shown in our region that by looking at the STS database outcomes linked to the clinical cost with evidence-based guidelines, which is actually door number C that was not alluded to before, that we can dramatically decrease the cost and improve the outcomes.

And the pay-fors, as we discussed, while the focus has been off the top payments, we can continue to deliver such care which is reflective of what you had said, Congresswoman, and show the improvement in care while decreasing such cost. And I think that this is, to dovetail on your previous question regarding fee-for-service, that is a totally outcome-exclusive proposition that is only focused on volumes of patients, procedures performed or tests that are done.

Mr. Schrader. Right. Completely the wrong incentive.

Dr. Speir. That is correct.

Mr. Schrader. I come from Oregon and very much into outcome based, and a nice way to marry up to primary care with the specialty care, and I think the way you guys are doing it is just really exciting and going to happen regardless of what we do, I think, here in Congress, and I am just really pleased with that.

Last question, if I may, with Mr. Schneidewind. The biggest concern I think a lot of us have is foisting too much of the cost, if you will, on the beneficiaries, and we struggle with this. I have been involved in different work groups trying to figure out how can we minimize that impact. I don't think my seniors are afraid to pay a little bit more as long as everyone is paying something, but they want to make sure they get the quality care that they get at the end of the day.

Some of the proposals with the means testing or the combining premiums, you talked a little bit about the deductible issues that seniors face, what if there were exclusions or work with your group and others to make sure that the low-income folks below -- pick a number, 200 percent of poverty level or whatever it might be -- are excluded from some of these beneficiary cost-sharing ideas, would AARP be willing to work with us on something like that?

Mr. Schneidewind. Well, one of the concerns that we have, and

we have seen this in the proposals to income relate, for instance, premiums, that right now somebody at the top range is paying three times the premium as somebody at the bottom. And we worry that the more those premiums go up, for instance, the more incentive these people have to simply go off Part B and seek their insurance elsewhere, because right now those premiums are very high. And some of the proposals we see, for instance, really start kicking in at $85,000 of income, whereas the IRS considers a wealth person $400,000.

You are really starting to reach down and increase the cost of care for a lot of people. Right now, as I have said also, the people, let's say half of the people are at $23,000 of income, and they are already paying $4,000 of that in medical care, and they are paying premium increases as they occur, and they have incurred steadily.

So we think with the very promising savings that are available in the prescription drug arena, through some other reforms, looking at the payments, for instance, to, you know, upcoding on Medicare Advantage --

Mr. Schrader. Okay. Very good. My time has expired. I will take that as a no, but thank you very much.

Mr. Guthrie. Thank you, Dr. Schrader.

Dr. Schrader's time has expired.

Mr. Lance of New Jersey is recognized.

Mr. Lance. Thank you very much, Mr. Chairman.

I would have been surprised if anybody on the panel had not favored a permanent solution. And I have read the testimony, including the suggestions that have been made. In my own view, it will be very difficult to achieve this by March 31. And, for me, the question is, is there a method to pay for a permanent solution that can pass both houses of Congress, be signed into law by the President of the United States? I think that is an extremely difficult question to answer.

And I am also concerned by the fact that the deadline approaches and we have other fundamental issues regarding healthcare policy that we may have to address in this session, particularly if the Supreme Court rules, as it may very well rule, that there can be no subsidies to the Federal exchange.

Is there anybody on the panel who might be willing to address that potential as it relates to SGR?

Don't all volunteer at once. Anybody on the panel?

My point, obviously, is that these are great issues with moving parts, and they are not simply an issue that relates to SGR, although SGR is an important component of it.

Mr. Umbdenstock, some say that SGR reform is Medicare reform rather than simply a physician payment bill, and in your report, "Ensuring a Healthier Tomorrow," there have been a number of suggestions made. What was the catalyst for the report, and why do you think that Medicare reform is important, particularly in the

context of SGR?

Dr. Umbdenstock. Thank you very much, sir.

First of all, the catalyst for the report was an update of our view of what additional changes need to happen, and that was done 2 years after the passage of the Affordable Care Act.

Mr. Lance. Yes.

Dr. Umbdenstock. So we updated our reform principles and framework. And in there we stressed not only the various issues that we think need to be addressed, but this notion of shared responsibility, that providers and consumers and suppliers and government and private sector, we are all going to have to make changes in order to get this done.

Secondly, SGR is important. It is critical. It has been kicked down the road for too long. The uncertainty that comes with it for physicians and therefore for patients and access, we have just got to solve it. But it is not the sum total of Medicare reform. So we have to think about solving this problem in the context of how the solutions may also help us in the long-term reform of the program, and that is why we proposed some of the things that we did for your consideration.

Mr. Lance. Thank you.

And to Dr. Speir, the Society of Thoracic Surgeons has a national database, and you have discussed that in your written testimony, and you have discussed the fact that it might be applied to the Medicare

program at large. And if you would discuss with the committee your views on that and the positive outcomes that you have experienced in your field from an innovative use of data and implementation of this program.

Dr. Speir. Thank you. We feel very strongly that the registries are really applicable not only to procedurally based practitioners, but really to all physicians, and that the time is now for us to not only be accountable and begin to participate with such registries regardless of our specialization, but then use that data in the turnaround to improve our care and therefore reduce the cost.

It is not only for the Medicare patients, but anyone that undergoes cardiac surgery or any procedures, or pulmonary resections for esophageal resections or anything to do within our specialty. These registries and the concept of that have also been expanded in other fields, whether it is vascular surgery, neurosurgery, and more and more are getting on board with that. But that is our future, all of us.

Mr. Lance. Thank you.

In conclusion, let me say I want to associate myself with the fine work of Dr. Burgess and also with the comments of Chairman Emeritus Barton. And I do think that we should look sincerely at Chairman Barton's suggestion regarding funding, perhaps to some extent from Internet poker. And the reason that this issue has not been resolved

institutionally in Congress is that it is a very difficult issue, and we have panels come before us all the time saying a permanent solution is necessary. It is much more difficult to determine how to pay for it.

Thank you, Mr. Chairman.

Mr. Guthrie. The gentleman yields back.

Recognize Mr. Butterfield of North Carolina.

Mr. Butterfield. Thank you very much, Mr. Chairman, and let me apologize for being late. I have been multitasking all morning long, as all of my colleagues do every day.

But thank you for coming, thank you to the six witnesses.

And thank you, Mr. Chairman, for convening this hearing.

I am encouraged by the hearing so that we can talk about the long-term concerns that are facing the Medicare program. My goal as just one single member of this subcommittee is to provide greater certainty for providers and beneficiaries, and I am happy, very happy, that there is a bipartisan agreement, as it appears, that is pursuing a permanent fix to the SGR as the most prudent way to go forward.

Since 2003, Congress has patched the formula, as we all know, 17 times at least, each time causing trepidation among providers and beneficiaries. Seniors in my district, including more low-income individuals and many African-American citizens, do not know if they will be able to see the same doctor next year. My providers do not

know if they will be able to serve the same patients next year.

So we can, Mr. Chairman, and we must come together and find a long-term solution to this problem, and this bill is a step in the right direction. Mr. Chairman, we can fix this thing. The pay-for is obviously the problem, but I believe that if reasonable minds can come together and forget the partisanship, and I think if we sit together, we can figure this thing out and get a permanent fix to this problem.

I will make the observation that it cost $144 billion to fix it over a 10-year period, and that is, indeed, a lot of money, but we have to talk about budgeting in relative terms. We spent $10 billion per month in Iraq, and that is 14 months of conflict in Iraq versus a permanent fix for the SGR. Mr. Chairman, we can do this thing.

Let me ask my question to the president-elect of AARP. I cannot pronounce your name. I am from the rural South, and I dare not even try it. But, sir, we have heard a number of proposals that would reduce the Medicare benefit for those currently on the program or those even eligible for Medicare. For example, we have heard proposals from others on the other side of the aisle that would gradually raise the Medicare eligibility from 65 to 67. You know all about that.

This proposal is very concerning to me because I think that it is a little bit shortsighted. Its consequences are far-reaching. These people will still need coverage, and certainly they will get sick. I also believe this change would be breaking a longstanding

intergenerational promise that we made to the American people.

Very quickly, can you speak to the effects of raising the Medicare eligibility age, at least on the members that you represent?

Mr. Schneidewind. Well, our feeling is that it represents really a cost shift, not a cost savings, and let me describe that. By raising the eligibility rate, you end up having people on their Affordable Care Act insurance, if they have it, for a longer period of time or their private insurance. That means that the pools there have to pay for an older population because the age to transfer to Medicare is extended. So the costs go up, and those costs are borne by businesses, by governments, and by those who provide insurance to their employees. So it hurts the economy.

On the other hand, for Medicare, it ends up making the population in the pool older on average, because coverage starts at an older age, and that increases Medicare costs. So you have increased costs for Medicare, you have increased costs for private and ACA insurance, you have increased costs for employers who hire people, and, because those effects now are being looked at, my information is that the estimates of savings from this measure have been drastically reduced by the Government Accounting Office, because they have fully understood now what this would really do.

Mr. Butterfield. So the cost of raising it by 2 years is insignificant in the scheme of things?

Mr. Schneidewind. Well, it has turned out to be a lot. The savings have turned out to be almost nonexistent when you look at Medicare, the private insurance market now, the ACA, and the fact that rather than eliminating costs, you are simply shifting the cost to different forms of insurance. So our information is that, yes, indeed, the estimates of the overall savings have shrunk drastically.

Mr. Butterfield. And that is the position of AARP?

Mr. Schneidewind. Yes, that we oppose the raising of the Medicare eligibility rate, because it would make Medicare on average more expensive, because the risk pool is now older. It would shift costs to the current employers, government, businesses, and others, make their plight worse. And because of that, we don't see net savings, we just see shifting in cost.

Mr. Butterfield. Thank you. Sir.

I yield back, Mr. Chairman.

Mr. Guthrie. Thank you. Gentleman yields back.

Recognizes Ms. Brooks from Indiana.

Mrs. Brooks. Thank you, Mr. Chairman.

This is to Mr. Umbdenstock. Did I get your name right?

Dr. Umbdenstock. Yes. Thank you.

Mrs. Brooks. Each year, and in my district of northern Indianapolis into the north, I hear from hospitals all the time, they dedicate so many resources and so many dollars to avoid the

unintentional technical violations of the Stark Act. And it seems to me that these paperwork-type of violations, which often come from often minor violations, result in the hospital paying millions of dollars in Stark Law penalties.

And I was a cosponsor in the last Congress of the Boustany-Kind, the Stark Simplification Act, that would limit the penalty a hospital can pay, can suffer for committing a technical violation, create an expedited process with CMS. But I think, more importantly, industry officials have produced reports showing they could generate a billion dollars in new revenue if this type of law were to be passed. Not a savings, but in fact revenue.

Can you please comment on whether or not you agree with this? Does the AHA support the Stark Administrative Simplification Act in the last Congress, and do you believe that it will actually generate new revenue?

Dr. Umbdenstock. Thank you very much for the question. And absolutely we are supportive and we appreciate your support of that bill. You are exactly right that hospitals are being tied up endlessly for situations that were unintentional, technical in nature, and had no adverse impact on the program or the beneficiaries. So we really want to see that type of relief instituted.

I have to say that I am not familiar, I am sorry, with studies that would show how this would increase revenue to the government.

Maybe you could help me.

Mrs. Brooks. If this bill were to be reintroduced, is AHA going to be supportive of Stark simplification?

Dr. Umbdenstock. Indeed. Indeed. Yes. Thank you.

Mrs. Brooks. And do you think it at least could be and maybe should be part of the discussion about a pay-for for SGR repeal? And how could they be connected?

Dr. Umbdenstock. Certainly, if it would produce savings and simplify the work experience, the overhead costs, the unnecessary costs of compliance to the hospital field, we would definitely see that as a plus.

Mrs. Brooks. To Dr. McAneny, I have appreciated the way in which you have given us some very concrete examples of how your patients are impacted, and I again want to also commend Dr. Burgess for his leadership on this issue.

Can you share with us a few more examples of how this bill would have the potential to help increase the quality and the services, delivery of care, to seniors and the disabled? How can we do a better job articulating to the general public how fixing the SGR will actually improve quality and delivery of care? You mentioned things of uncertainty in physicians' practices, but can we talk a little bit more specifically with respect to quality of care for patients?

Dr. McAneny. Certainly, and I very much appreciate that

question.

Right now there is a limited amount of money in any physician practice that we can spend on improving what we do, and all of that money is currently getting diverted now into trying to comply with Meaningful Use, trying to comply with PQRS, filling out all of the various insurance company requirements for quality measures, often quality measures that are not applicable to our specific specialty. And this bill, I think, is a good vehicle to do that, to consolidate that. We could then take that amount of money and start to look at alternative payment programs.

So to get very specific, in our practice and in the six other practices across the United States that are participating with us in creating the oncology medical home, what we have done is spend a lot more of those resources on teaching patients how to use the system, how to get help from us when they need it, what do they need, having pharmacy techs who can call up and re-explain what is going on with their medications, having nurses on the phone answering questions, having same-day visits and same-day appointments so that patients seek care at a lower cost side of service by physicians who know them rather than going to the emergency department who is set up to deal with car accidents and heart attacks and not really cancer patients.

So the point is that many physicians in various specialties have the ability to really designate things that will make a difference in

their individual practice if we weren't busy trying to use all our time, money, and resources on complying with these other entities.

Mrs. Brooks. Thank you.

And thank you all for saving lives. Appreciate it.

Mr. Guthrie. Gentlelady's time has expired.

We recognize Mr. Cardenas of California.

Mr. Cardenas. Thank you very much, Mr. Chairman.

I have a question for Mr. Schneidewind. Some proposals suggest one option for raising more money for Medicare is additional income relating to the Medicare Part B premium. Aren't Medicare premiums already income related?

Mr. Schneidewind. Well, yes, they are. In fact, they span, they are multiplied almost three times from the basic level if you are at the upper-income level of about $213,000. So that the truth of the matter is they are heavily income related, and we fear that if they are increased too much more people who are paying that may find other forms of insurance attractive and leave the Medicare pool. And that is a problem because studies have found that the upper-income group tends to be more healthy, and, frankly, they are making a contribution to Medicare economics, and if they leave the plan will be disadvantaged.

I guess the other thing is that proposals in terms of income relating are reaching down into levels of income that are hardly wealthy. I mean, IRS thinks that $400,000 of income is wealthy, and

yet some of these proposals would reach down to people making $50,000, $40,000, and that is not wealthy.

Mr. Cardenas. No, I would say it is not. It doesn't matter what part of the country you are in.

Part of your response referred to the income averaging of a program. In other words, how revenue comes in and where do you get that revenue, et cetera. And if certain components are actually pushed out of the system or are encouraged to leave the system, then that would cause some kind of imbalance to the entire system, correct?

Mr. Schneidewind. Right. If you push out of the system people, number one, who are paying the most, by a factor of 3 right now, number two, tend to be healthier than average so they impose less cost on the system, what you have done is deal a blow to both the revenue and the cost adversely. You are raising costs and you are decreasing revenue. So we think that really at this point the income-relating features have gone about far enough, and if they go further, they will produce those undesirable effects.

Mr. Cardenas. Now, on one side you referred to plan premium. In other words, how much somebody is paying to have that plan in effect for them and/or their family. Yet at the same time, when somebody is looking at a premium it doesn't necessarily mean that they are comparing apples to apples when it comes to what benefits they are getting for that other plan, correct?

Mr. Schneidewind. Well, you mean --

Mr. Cardenas. I mean, it is not inherent. For example, if somebody is paying X amount premium for coverage with Plan A, and then all of a sudden they are just looking at the premium mainly and they say, well, this premium is $10 less a month, I am going to go that, it doesn't necessarily mean that the person is getting equal coverage for less money. It could be that they are actually going to something that they don't realize until later, maybe after being it for a year or two or what have you and saying, wait a minute, I am talking to my friend Edna who lives next door, she stayed on Medicare, I went to this other plan, and she, as it plays out, I might be saving a few bucks a month, but at the same time the overall plan, she is actually getting more benefit.

Mr. Schneidewind. That is correct. And I think AARP very strongly believes that it pays to be a smart shopper, that what we have seen is that there is a rapid annual shift in premiums, even the same plan. So we advise our members and try to help them seek out the most advantageous plans and compare apples to apples, as you have said.

Mr. Cardenas. Well, I think it is important for us to understand that, especially the lower-income Americans, what have you, although they might be very smart or what have you, but might be making decisions without being very well informed. Yet at the same time when it comes to the plan layout as it is today, there was a lot of thought and calculus

going into that already, correct? At least on the end of putting these plans out there.

Mr. Schneidewind. Well, sticking just to Medicare, of course, you know, that is a uniform benefit, although there are chances to go to Medicare Advantage. You have that choice. If you go to a traditional Medicare there are certainly a lot of supplements out there. Customers have proven very capable of choosing among those. And as I said, AARP certainly has tried to make and help our members be wise purchasers.

Mr. Cardenas. Yeah. I would like to commend AARP, because when they showed me how involved they were in this new paradigm shift, that they were actually one of the best Web sites I had seen out there, and they were doing it on their own volition. And I think it not only educated seniors, but it educated family members beyond that. I know that when my parents were around, us kids always got involved in these decision processes. So it was a learning experience not only for them every time we did that, but it was something we took with us. And now that I have my own family, I am glad that that opportunity took place.

Thank you very much, Mr. Chairman. I yield back my time.

Mr. Guthrie. Thank you. The gentleman's time has expired.

The chair recognizes Mr. Collins from New York.

Mr. Collins. Thank you, Mr. Chairman. If we could ask the witnesses to kind of speak right into the microphone to hear you. I

mean, it is almost impossible.

First of all, my question is going to be directed at Dr. McAneny and Mr. Umbdenstock. But first I want to thank Mr. Schneidewind for your comment on the age 67 cost shifting. It is a very poignant point.

Mr. Guthrie. Mr. Collins, is your microphone on? I request that you speak into the microphone.

Mr. Collins. I am speaking into it, but it wasn't on. I guess Ms. Brooks turned it off.

But I also have a request. Can you take my wife's name off your mailing list? She doesn't want to be reminded she is 50 years old. So if you could do that, I would appreciate it.

Mr. Schneidewind. I will do my best.

Mr. Collins. My comment really is on the defensive medicine side and the need for medical insurance liability reform, which the CBO says could pay for half of this SGR fix, but also save a lot of money in other areas beyond Medicare.

If I could ask, Dr. McAneny, maybe spend 2 minutes on that or a little less, and then shift it over to Mr. Umbdenstock, how the defensive medicine piece plays in. And I have heard numbers it can be as much as 20 percent of our medical costs, running tests and the like that really aren't necessary. But defensive medicine against lawsuits.

Dr. O'Shea. Dr. O'Shea will answer your question.

I come from California. In California we have MICRA. MICRA is a gift. MICRA is a gift to physicians. MICRA contains our medical malpractice insurance. I always tell my patients I am glad that I have medical malpractice, I am human, if I make a mistake, I really want you to be able to garner the best benefits for it. But that doesn't mean outrageous fees for the pain and suffering that mostly don't go to the patient either.

When you have contained costs this way, it lowers the overhead. And private practitioners will tell you we live on a margin. I know some of my OB-GYN colleagues, including my husband who is an OB-GYN, can work 4 to 5 months out of the year just to pay for their medical malpractice. Where does that leave a private practice to do any kind of innovation, to do any other kind of cost savings in their medical home, develop other systems to try and innovate for their patients, when you are your own practice? Medical malpractice is a big issue that is not going to go away. We do want to have it, but we want to have it where it actually benefits the patient and maybe not someone else.

Dr. Umbdenstock. Thank you, sir, for the question, and I would agree with the sentiments just expressed. Yes, it is a big issue. Our costs in that area continue to rise. But as you point out, it does encourage defensive medicine. That only exposes patients to more interventions, for more potential for things to go sideways or not well.

The estimates I have heard are similar to what you say, about 20 percent, one in five decisions some physicians tell me.

I think we need to think about a more expeditious approach, to Dr. O'Shea's last comment, that really does help the aggrieved patient quicker, more simply, more respectfully, something that encourages the practitioner and provider organization to come forward and acknowledge if something has gone wrong, an open apology to the family, work together, but look for more of an administrative approach, and the AHA can provide ideas on how to do that.

Mr. Collins. Thank you.

One last word, then, from Mr. McAneny.

Dr. McAneny. Yes. Thank you very much.

The AMA has extensive policy on the effects of professional liability on the ability to deliver care. It is at best a diversion from the things that we want to be able to do.

If we were able to, again, redirect all of the efforts that are made towards triple checking and quadruple checking ourselves by getting more and more testing in order to be able to cover ourselves I think we would be able to divert a lot of that money into things that would be better care for patients. So the AMA is happy to work with the committee on trying to look at what the effects of professional liability reform would be.

Mr. Collins. Real quickly, we have 30 seconds, could I just ask

each of you, do you agree that the need for medical malpractice reform is right at the top of the list?

Dr. Umbdenstock. Yes.

Dr. McAneny. Yes.

Mr. Miller. Absolutely.

Dr. Speir. Yes.

Mr. Schneidewind. I am not sure that that would be at the top of our list.

Mr. Collins. But it is important.

Mr. Schneidewind. It may be important. I haven't prepared a detailed answer on that, but we will look at it.

Mr. Collins. Yeah. Very good. Thank you all very much for your participation.

Yield back, Mr. Chairman, 5 seconds.

Mr. Guthrie. Thank you. I appreciate the gentleman for yielding back.

The ranking member of the full committee is recognized for 5 minutes.

Mr. Pallone. I am sorry, Mr. Chairman, I didn't realize who you were talking about. But that is okay. I guess it takes a while.

I wanted to ask Mr. Schneidewind, hope I am pronouncing it properly, I am concerned that some would tie the SGR to other poison pills that would cut access to care or increase costs on beneficiaries.

And seniors already bear significant out-of-pocket costs in Medicare, and most are living on very modest incomes. In fact, half of all Medicare beneficiaries have incomes below $23,500. You have heard that figure.

Can you talk a little about a typical income of Medicare beneficiaries and the out-of-pocket costs, you know, premiums, deductibles, other cost-sharing burdens that beneficiaries already bear as a share of their income.

Mr. Schneidewind. First of all, the $23,500 income and 17 percent of that income is spent on medical care, that is $4,000 out of $23,500. I mean, that is huge already. It represents about 25 percent of the average Social Security benefit that these people get. Once again, huge amounts.

Now, these people already pay a Part B premium of about $105 roughly per month, and then on top of that they pay their deductibles and copays, and some of them may end up buying, if they have standard or traditional Medicare, may end up buying supplemental coverage as well.

So you can see that not only in percentage of income, but they have seen increases. They fully participate, for instance, every time Medicare Part B premiums go up, as they do and as they have, the people who buy that coverage are participating in paying for those increases.

RPTR HUMISTON

EDTR WILTSIE

[12:10 p.m.]

Mr. Schneidewind. So we believe that the burden on, particularly, lower-income people, but all people, is very significant, and AARP really believes that, if there are savings to be made, if there are offsets to be made, that we need to look at economies and prescription drugs in terms of payment reforms, such as are contained in this legislation, and other things, such as competitive bidding for durable medical equipment and things like that.

Mr. Pallone. And then, I mean -- yeah. I am kind of putting words into your mouth.

But when costs are too high, I assume a lot of beneficiaries in some cases just forego care. And do you want to just talk about the consequences of that briefly.

Mr. Schneidewind. Yes. You know, that is a particular concern of ours when discussion is had about increasing co-pays or deductibles.

The downside of that is that people then are reluctant to go in and see their healthcare provider, whether it is a hospital or a doctor, and they may not get the care they need.

And then, of course, down the road, it may be that they have a condition that worsens drastically for lack of a modest amount of care

and then becomes a burden on the entire system.

So we really believe that many of the proposals to increase deductibles and co-pays will produce higher costs for the system and have adverse consequences. We don't believe it is good for providers, the public, or the recipient.

Mr. Pallone. Okay. Thank you.

Dr. O'Shea, I believe that ensuring appropriate access to primary care is critical to improving our healthcare system, and one of the goals behind the ACA was moving our system to one of prevention so that we are not always treating sickness because of the cost, in part.

And, as you know, one of the provisions in the ACA was increasing payments for Medicaid primary care doctors to Medicare rates. Obviously, I think that is a good thing.

And I guess -- let me just skip some of this and ask you the two questions because we are running out of time.

One, does the AOA support extending the primary care increase in Medicaid? And can you talk about what effect this bump has had across the country. And do you believe it is an effective way to address access?

Dr. O'Shea. Can I say yes?

Mr. Pallone. Okay.

Dr. O'Shea. No. Sir, the access to primary care is so necessary when you are actually talking about this mostly chronically ill. Why

are -- in California, we call it Medi-Cal.

Why a lot of times are they actually at this level? It is not just income. They have already had acute and then chronically ill patients that can't work, can't, you know, economically have their own ways to have higher care.

Yes. The bump has helped, especially in California, because there was a 10 percent cut not too many years ago where, you know, if you are not in a larger system, it is hard for smaller primary cares to actually accept those lower-paid patients. You know, they will pay us at something like 20 to 22 cents on the dollar for what other insurance will.

So, yes, you have the most needy population that then would cost the most for the hospital systems because that is where they are headed if they don't get the primary intervention earlier. That small boost has been made.

So primary care that has an efficient system can actually help those patients and it has been able to access more of those patients and provide care for them.

Mr. Pallone. Thank you.

Thank you, Mr. Chairman.

Mr. Guthrie. [Presiding.] Thank you.

The ranking member Mr. Pallone from New Jersey's time has expired.

And I will recognize Mr. Long from Missouri.

Mr. Long. Thank you, Mr. Chairman.

And thank you all for being here today.

Yesterday the subcommittee heard from policy experts with experience in building bipartisan consensus on Medicare reforms.

And when they were asked about whether further study of various options was needed, their view was that Congress has enough information already, we are kind of talking the thing to death, and now is the time for Members to sit down and agree to a package of offsets to make SGR history.

So I want to start with Mr. Umbdenstock. Is that it?

Mr. Umbdenstock. Yes, it is.

Mr. Long. Something like that.

Mr. Umbdenstock. Thank you.

Mr. Long. I knew I would call you "Byalistock" or something.

But just a yes or no. I will start right there and go right down the line. Just a simple yes or no answer will suffice. And I want to hear briefly from each of you.

Do you believe now is the time for Members to sit down on a bipartisan basis and agree to bipartisan offsets on SGR reform? Yes or no.

Mr. Umbdenstock. Yes, sir. And we have put some suggestions in our testimony. So we would be happy to talk to you about those.

Dr. O'Shea. Emphatically yes, sir.

Dr. Speir. Yes. And, in part, your second question, if not now, when?

Mr. Miller. Yes, sir.

Dr. McAneny. Yes. We very much would appreciate you doing that. We have got such good policy that has come out of this committee. If we can push it over the line, we can get on with other changes we need to make. So, yes, please.

Mr. Schneidewind. Yes, Congressman. We have a list of offsets that we have offered to help that process.

Mr. Long. Unanimous. I like that.

Because like I -- in Washington, sometimes we can get in the habit of talking things to death. And everyone wants to do something in a bipartisan fashion and the public wants to see that. Our constituents are always asking, "Why can't you do something in a bipartisan fashion?" And I think the time is now.

Mr. Umbdenstock, I realize that forging consensus within an industry trade association such as yours on changes to Medicare can be very challenging. However, the Hospital Association, as you know, has endorsed roughly $2 trillion in potential offsets for Congress to consider.

Given your success in getting your members around these offsets, do you have any insights you can offer in working to build cooperation and consensus with others in the provider community and the Members

of Congress?

Mr. Umbdenstock. Just a couple of quick comments, sir.

One would be that every thought we have about this has to be put up against the prospect of a 21 percent cut to physicians, with physicians probably backing -- many of them backing out of the program and causing huge access problems for Medicare beneficiaries. Everything has to be seen in that light.

Number two, hospitals have already consumed -- absorbed $121 billion in cuts, and we don't believe that we should be asked yet again to make sacrifice in that sense.

We need to see shared responsibility here. All of us need to contribute to the solution to this problem, and that is behind the paper that is appended to our testimony that went through about 500 different members in our group to put that together.

Mr. Long. Do you think that we might suffer from a physician shortage if these cuts continue?

Mr. Umbdenstock. Well, I think we already do. And we are supportive of lifting the caps on graduate medical education positions.

That is going to be a long-term solution. We need other solutions in the meantime. But certainly it is going to encourage some physicians to think second and third about continuing the program or even retiring.

Mr. Long. That is exactly what I faced with my personal doctor.

And a lot of people I know, doctors have retired. Most doctors I talked to are looking for a way out. And with my daughter just about to graduate medical school, I know that this doctor shortage is coming.

So, anyway, thank you all once again for your testimony.

With that, I yield back 60 seconds.

Mr. Guthrie. I appreciate the gentleman for yielding back.

The chair recognizes Mr. Bilirakis of Florida.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it very much.

First question is for Mr. Richard Umbdenstock. I hope I pronounced it all right.

Mr. Umbdenstock. Yes, sir.

Mr. Bilirakis. In your testimony, you noted that traditional Medicare does not have an annual out-of-pocket maximum payment cap to protect seniors from financial hardship or bankruptcy in the event of a major illness.

Yesterday, as part of my questioning, Senator Lieberman talked about how important a maximum out-of-pocket protection -- how important that is and how this is the reason most Americans buy health insurance. Makes sense. Unfortunately, traditional Medicare does not offer seniors this peace of mind.

Can you talk more about how this reform could lower Medicare spending and help seniors at the same time.

Mr. Umbdenstock. Yes. Thank you very much.

One overall comment: I think we need to think about the fact that structural changes are one thing and where you set the dollar limits of responsibility are another thing.

If we just talk about dollar limits and impact without talking about structure and opportunities for change, I think we miss a lot of the important part of the conversation.

As you point out, we may focus heavily on premiums, but if we don't focus on total costs and total financial responsibility, we miss the bigger picture.

So, yes, we would be in favor, as we talk about the A and B construction or other structural changes, of seeing how we can maybe up the financial responsibility on some people -- proper protections for those at low-income level, phase it in over time -- you know, do it right, but at the same time think about things that currently don't exist in the program, such as a cap. And that would be -- you know, on a catastrophic sense, that would be really important to do.

Mr. Bilirakis. Thank you so much.

Again, for you, sir, according to the CBO, Medicare spending will continue to climb over the coming decade, totaling more than $1 trillion in 2024.

One of my worries is that, as Medicare costs grow and consume more general revenue dollars, it will crowd out other domestic discretionary

priorities, such as NIH research and, of course, the VA health care, which I care about deeply.

What Medicare reforms do you think could be adopted with the SGR that would help curb Medicare spending the most?

Mr. Umbdenstock. Well, we -- as was pointed out by the gentleman just a minute ago, we have put forth several suggestions in our testimony.

We have also looked across all of the items that have been scored by CBO in the healthcare space and have offered that up on our Web site as a longer list of possibilities.

I think we would have to talk about what changes and in combination with what other changes rather than any one major bullet, so to speak. May be a bad choice of term. Pardon me. But the ones that we put forth in our testimony are ones that we think hold great promise and should be examined.

Mr. Bilirakis. Okay. I would like to maybe mention one again for you, Mr. Umbdenstock.

According to the Social Security Administration data, there are thousands of seniors with annual incomes of more than a million dollars.

In your testimony, you address the issue of premiums and mention the Government subsidizes the premiums for everyone, including millionaires. You also mention that the American Hospital Association supports increasing income-related premiums.

Can you talk about why you think it is reasonable to charge them more.

Mr. Umbdenstock. Well, I think each of us has to share in this responsibility individually as well as organizationally. So that is the first principle.

Secondly, we do want to see protections continue for those of low income and low means for sure. It doesn't help us at all to charge something to somebody that they can't afford.

That just increases administrat -- it certainly increases the negative experience for the patient. It increases our administrative costs. It increases our bad debt.

We have had debates with Congress over the level of our bad debt reimbursement. So it doesn't solve any problem for us.

But where somebody can afford it and where we can do it more efficiently with the right protections for those who can't, I think we should.

Mr. Bilirakis. Very good.

Thank you, Mr. Chairman. I will yield back my 29 seconds. Thank you.

Mr. Guthrie. Thank you.

The gentleman yields back his time.

Mr. Bucshon of Indiana is recognized for 5 minutes.

Mr. Bucshon. Thank you, Mr. Chairman.

And many of you know I was a practicing cardiovascular and thoracic surgeon for 15 years prior to coming here. And this is one of the issues that got me to come here because I have a big concern, as we all do, basically, at the end of day, about our patient.

And that is what this is all about. Everything we discuss today needs to be framed in the context of how we can better take care of patients, and I think that is what I try to do.

I have supported outside pay-fors -- pay-fors outside of the healthcare sector to try to address the SGR historically. And, by the way, I did submit all of my cases to the STS database.

And I think the STS database is really on the forefront of quality analysis and it does definitely, I can tell you from personal experience, direct where you practice your -- how you practice your medicine.

I always compared myself to my peers and saw how things were going and tried to do everything I could to improve the quality of the care that I offered.

The other thing is, briefly, when you also -- in addition to the SGR, we clearly need to address overall healthcare costs. One of the ways to help Medicare, of course, is to have the cost of healthcare come down.

And we need more, I think, as the STS database attests, quality information as well as price transparency for the consumer, which is

a huge problem, in my estimation, as well as tort reform, which has been discussed. And there is a laundry list of other things that can help us get the overall cost of healthcare down.

Dr. McAneny, I am going to ask you about -- the AARP, as well as the AHA, have submitted ideas on the pay-fors for SGR. And, historically, the AMA has supported repealing the SGR without pay-fors. We could use your -- we can really use your help -- your organization's help in offering pay-fors.

Can the AMA offer some substantial possible pay-fors for us to look at to help us repeal the SGR?

Dr. McAneny. Thank you very much for that question.

It is a very difficult one because, within the healthcare sector, so many people are struggling now just to keep their doors open to their patients that for us from within the healthcare sector to really come up with a specific pay-for may not be as useful until there are some guidelines set up by Congress on what are the rules of this particular budgetary process, how do we fit those things within that.

I think the AMA stands ready to assist and help by weighing in on any given suggestions, but I think we are very uneasy and feel that we don't really have the ability to give you specific pay-fors. The devil in this is all very much in the details. So --

Mr. Bucshon. The reason I say that is because -- I think it is important that you really seriously consider offering some options.

And the reason I say that is because, in the public's mind -- okay? -- the support of the AMA on an issue, for better or for worse, is often used as an up-or-down on something related to healthcare. And you know this as well as I do.

Dr. McAneny. Right.

Mr. Bucshon. Because, if the AMA, for example, offered pay-fors, you know, around the country when this discussion comes up, it will list in there, "And the AMA supported this."

If the AMA is not there and the AMA doesn't comment, then it is going to say, "Well, we asked the AMA and they" -- you know, "they didn't respond to our request" and so it appears that the AMA may not be supporting.

You understand what I am saying?

Dr. McAneny. [Nonverbal response.]

Mr. Bucshon. And what it is used for is it is used politically. It is political. It is a political way to -- if something is not tenable to certain groups, to use the AMA's up-or-down support on an issue as the reason for why it is not happening.

And so I would just implore you to really reconsider that -- you know, the AMA reconsider and maybe help us rather than waiting, you know, for other options and then coming out and saying, "Well, up or down, we disagree" or "we agree."

I mean, I think, in all of our lives -- right? -- if you are going

to offer an opinion at the end, then you should be part of the -- offering solutions on the front side.

Because, in fairness, I think, you know, whether it is within your own family or whether it is to solve this problem, if you are just going to wait and be a critic and not offer solutions yourself, to me, that is not very helpful.

So with the remaining 18 seconds, just please reconsider and really try to -- try to really help us. You can help us with this problem with offering solutions.

Mr. Chairman, I yield back.

Mr. Guthrie. Thank you.

The gentleman yields back.

Mr. Griffith of Virginia is recognized for 5 minutes.

Mr. Griffith. Thank you, Mr. Chairman. I appreciate it.

Let me touch on tort reform, medical malpractice, just briefly.

I heard the testimony about California's plan. Works great for California. But we have had some bills in the past that wanted to take the California model and apply it nationally.

One of the problems I have with that, coming from Virginia, is that California has a comparative negligence model in their entire -- all of their torts, not just medical malpractice.

Virginia is not a comparative negligence state. It is a contributory negligence state. So if you adopt the California

model -- it is one of the things we have to be careful for in Congress. If we adopt the California model and apply it statewide, we completely reverse 400 years of Virginia law.

There are ways to have tort reform without making it one-size-fits-all from Washington, and I think that is probably what most people would want us to do. So we just have to be careful.

So if occasionally you see people talking about tort reform and then something happens on the way from here to the floor, you understand why that might occur.

But you would agree that tort reform -- and I will ask the gentlelady the question from California.

You would agree that tort reform is something that would be helpful in this process as long as we make sure we are not trampling over the general laws of the State?

Dr. O'Shea. I totally agree. And I can say, being a practicing physician in California, our Practice Act had been opened. And so it might be analogous to that, that you always have to -- that the Pandora can jump in and many Pandoras jump back in again, out and in.

But if it is an access to patient care, if it is not abling especially specialists or even primary care -- if they want to treat indigents, if they want to treat others, you are lowering their ability to have their own funds that they need, that they have to generate some way. So there is another way. Is it coming from or is it going out

of?

So I would totally agree that we have to be sensitive to each State, but limiting malpractice is something that needs to be done.

Mr. Griffith. And I would hope that the other respective States would do what California has done, what Virginia has done, what Texas has done now. And each State has their own model.

In Virginia, they have done a great job. And I can't take any credit for it, although I served there. But the doctors and the trial lawyers got together and came up with caps.

And sometimes they argue about it, but they come to the legislature generally with a plan of what we want to do, does the cap need to be raised, does this need to be changed, et cetera.

And they have worked together as opposed to getting into pitched wars, which makes it a lot easier on legislators to figure out, "Okay. If they are in agreement and they can both live with it, then it is probably makes pretty good sense." And I would encourage the other States to do that as well.

Let me ask Mr. Schneidewind this. Last May the Office of the Actuary at CMS said that Medicare's hospital insurance trust fund could be insolvent as soon as 2021 or as late as 2030. Under current law, there is no ability for the program then to pay claims on behalf of seniors.

Given these empirical facts, do you acknowledge that, if left

unaddressed, Medicare's coming insolvency could present an access problem for seniors on Medicare? It is an easy answer.

Mr. Schneidewind. Well, if it doesn't have the funds to pay claims, it would certainly have an impact on seniors.

Mr. Griffith. Absolutely.

On another policy issue both for you and the AMA, the President's 2015 budget to Congress includes a proposal that would apply -- or included a proposal that would apply a $25 increase to the Part B deductible in 2018, 2020 and 2022, respectively for new beneficiaries. Beginning in 2018, current beneficiaries or near-retirees would not be subject to the revised deductible.

Has your organization taken a position on this policy? And, if so, what is it?

Mr. Schneidewind. Yes. We have taken a position in opposition to that proposal.

And we have said before the burden of medical costs on our members is significant. Half of them have an income of less than $23,500 a year and they pay -- on average, that group pays $4,000 for medical costs. Also, as Medicare premiums, Part B, are raised, they pay those increases.

So imposing yet another deductible increase or expense on this group is really, we think, unaffordable, and we think there are far better ways to restrain costs in healthcare, in general, and in the

Medicare program, in particular, than raising premiums or deductibles.

Mr. Griffith. And Dr. McAneny.

Dr. McAneny. Thank you for the question.

We don't have any immediate policy on the President's budget proposal that we just heard on the State of the Union very, very recently, but we do have policy that we want to help consumers pay our patients to spend wisely and make wise choices.

Many of our specialty societies have adopted programs that we work with on choosing wisely to use those procedures that are helpful and not use the ones that are not needed or could be avoided.

There is literature that deductibles and co-pays can both decrease access to useful care as well as unuseful care. So we think that this is going to be a more complicated issue. We will be happy to get back to you on that and work our way through that.

Mr. Griffith. I appreciate that very much. Appreciate your testimony.

And I yield back.

Mr. Guthrie. Thank you. The gentleman's time has expired.

All Members seeking recognition have been recognized. And I want to remind Members that they have 10 business days to submit questions for the record.

And I ask the witnesses to respond to the questions promptly.

Members should submit their questions by the close of business

on Thursday, February the 5th.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:34 p.m., the subcommittee was adjourned.]