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MEDICARE'S FUTURE: AN EXAMINATION OF THE

INDEPENDENT PAYMENT ADVISORY BOARD

TUESDAY, JULY 12, 2011

House of Representatives,

Committee on the Budget,

Washington, D.C.

The committee met, pursuant to call, at 10:05 a.m. in room 210, Cannon House Office Building, Hon. Paul Ryan [chairman of the committee] presiding.

Present: Representatives Ryan, Akin, Price, McClintock, Chaffetz, Stutzman, Lankford, Black, Ribble, Flores, Mulvaney, Huelskamp, Young, Amash, Guinta, Woodall, Van Hollen, Schwartz, Blumenauer, McCollum, Yarmuth, Pascrell, Wasserman Schultz, Moore, Castor, Tonko, and Bass.

Chairman Ryan. The committee will come to order. We will begin our hearing. Madam Secretary, I know how excited you are to be here today. Thank you for coming.

I will begin with some brief opening remarks, then I will turn it over to Mr. Van Hollen, and then we will get started.

First of all, I want to thank you, Madam Secretary, and our other panel of witnesses for coming to today's hearing on the future of Medicare. For years, politicians in both parties have not been honest with the American people about Medicare. The facts are clear. Health care costs are skyrocketing, growing at 8 percent a year. Medicare spending is on pace to double over the next decade, exhausting its remaining funds. Ten thousand baby boomers are retiring every day as fewer workers are left paying into the program. Life expectancy was at 70 when Medicare was created. Today it is 79. Nonpartisan experts, including the Congressional Budget Office and Medicare's own trustees, repeatedly warn of the looming insolvency of this critical program. These aren't Democratic facts, these aren't Republican facts. These are facts.

Rather than advancing solutions to address these facts, too many politicians from both parties in the past, in Washington, have offered nothing but empty promises and false attacks. We deserve better. Our seniors deserve better. Due in large part of this committee efforts, I believe that the debate is shifting to better reflect Medicare's inescapable math. President Obama was exactly right when he stated yesterday, "If you look at the numbers, Medicare in particular will

run out of money and we will not be able to sustain that program, no matter how much taxes go up. It is not an option for us to just sit by and do nothing." I couldn't have said it better myself.

Senator Joe Lieberman, who has worked in a bipartisan manner to offer ideas of his own, put it well when he recently said, "We can only save Medicare if we change it."

The purpose of this hearing is to examine the changes to Medicare made by the President's health care law. Specifically, we wish to seek to better understand the Independent Payment Advisory Board's role in achieving the hundreds of billions of dollars of savings called for by the President. While I imagine we will hear about the many different expansions of government buried in this 2,700-page law, today's hearing is simply focused on page 1,000, section 3,403.

The Independent Payment Advisory Board, or IPAB, as we call it, is a new executive branch agency created by the President's new health care law. The law empowers this Board of 15 unelected officials with the authority to reduce Medicare spending. Unless overturned by a supermajority in Congress, the recommended cuts dictated by this Board will become law.

Bipartisan concerns have been raised with several aspects of this Board. While the proponents claim that the beneficiaries will be held harmless by the Board's decisions, how can IPAB impose sharp cuts to providers without an adverse impact on their patients? Given their unprecedented new power over Medicare, to whom are these 15 bureaucrats accountable?

There are bipartisan concerns on this question. Democrats, including some members of this committee, have raised concerns with Congress turning its responsibilities over to this Board. Seniors are also seeking clarity on the President's recent efforts to expand this Board's power over Medicare. In an April speech, the President called for IPAB to enforce further restrictions in Medicare's growth rate, down to GDP plus .5 percent. The health care law is also driving Medicare's reimbursement rates well below the artificially low Medicaid rates. According to Medicare's chief actuary, Richard Foster, the health care law will pay doctors less than half of what their services cost at the end of the decade, and down to 33 percent in decades ahead. Foster warns that these cuts are driving Medicare providers out of business and resulting in harsh disruptions to the quality and access for seniors.

Yet the President's framework calls upon IPAB to slash reimbursement rates even further than this. It remains incumbent upon the administration to specify how this Board will squeeze hundreds of billions of dollars of additional dollars from Medicare over the next decade, as the President has now proposed.

I want to thank Secretary Sebelius, I seriously do, for testifying today, for coming here to address these concerns. There is no question that we have differences on how to address Medicare's unsustainable future. But I appreciate your commitment to clarifying this debate for policymakers and for the American people.

I also want to thank our second panel of distinguished health care

experts who will further discuss the merits of this approach. We look forward to testimony from former CBO Director, Doug Hotlz-Eakin, Grace Marie Turner of the Galen Institute, and Dr. Judith Feder of the Urban Institute. Thank you all of our witnesses for the contributions to this debate. And I want to thank you all for joining this conversation.

With that, I would like to yield to the ranking member, Mr. Van Hollen, for any opening remarks he may have.

[The information follows:]

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Mr. Van Hollen. Well, thank you, Mr. Chairman. I want to join Chairman Ryan in welcoming you, Madam Secretary, to the panel and to the other witnesses we are going to hear from later. And I want to commend you on two initiatives you have recently undertaken to help implement the Affordable Care Act. One are the rules, guidelines that you recently released to govern the exchanges, which will open the door to millions of more Americans being able to get affordable health care in the United States of America. The other that received less attention is your recently announced initiative to improve the coordination of care for individuals who are both on Medicaid and Medicare, called the "dual eligibles." And as you have pointed out, using some of the innovative approaches in the Affordable Care Act, we can both improve the quality of care and save money through some of the changes you are proposing there.

Those are important parts of the Affordable Care Act that, together with others, will strengthen health care protections for the American people, including provisions that have already taken effect, including making sure that insurance companies can no longer discriminate against kids with asthma, diabetes, or other preexisting conditions by denying them coverage, including making sure that young people up to the age of 26 can stay on their parents' health care plans; including providing tax credits to hundreds of thousands of small businesses who can now afford to provide coverage to their patients; and including beginning and ultimately closing the prescription drug doughnut hole in Medicare that many seniors find themselves trapped

in.

Those are some of the important improvements that have been made. So I believe that the fundamental question, the fundamental underlying question of today's hearing is, what is the best way to strengthen our health care system; and specifically, how do we keep the promise of Medicare and meet the challenges of Medicare, as the chairman has said?

One way, one approach, is to build upon the very important reforms that were enacted in the Affordable Care Act. The Medicare trustees have found that those measures will indeed reduce the per-capita costs for Medicare beneficiaries going forward, the increase in per-capita cost, that it will help bend the curve, and that it will, in fact, extend the solvency of Medicare. We need to build upon those approaches.

As we have heard in testimony before this committee, from Dr. Rivlin and others, the Affordable Care Act opens all sorts of new avenues to try and modernize the structure of Medicare, which we need to do. We need to change the incentive structure so that it rewards the quality of care, the value of care over the volume of care and the quantity of care. And Mr. Chairman, we agree that significant changes need to be made to modernize the system in this way.

The Independent Payment Advisory Board is simply one tool in the tool box for getting it done. It creates a back-stop or a fail-safe provision to ensure the continued solvency of Medicare if, and only if, the Congress chooses not to act, to take other measures to build upon the kind of changes we saw in the Affordable Care Act.

And by the way, the IPAB is specifically prohibited by law from

changing Medicare benefits. That prerogative is reserved to the Congress. Moreover, the latest CBO projections indicate that the rates of growth in spending per beneficiary are below the target rates of growth for fiscal years 2015 and 2021 set forth in the Affordable Care Act, and therefore CBO projects that under current law, the IPAB mechanism will not affect Medicare spending during the 2011 to 2021 period. So building on that approach is one way.

What is the other approach? The other approach is a path set forward in the Republican budget plan, a plan that will end the Medicare guarantee and will force Medicare beneficiaries into the private insurance market. That plan is a double whammy, a double whammy for Medicare beneficiaries for the following reasons: First, the Congressional Budget Office has determined that that plan will actually drive up overall health care costs. It changes the allocation of the burden, but it drives up overall health care costs. Why? Because providing that care in the private market is more expensive. And, in fact, if you look at the history of per-capita growth rates in the private market compared to per-capita growth rates in Medicare, Medicare has actually outperformed the private market. And therefore you are saying to those seniors, we are going to toss you into the private insurance market where you are going to face higher premiums and costs.

Why is it a double whammy? Because as you do that, you dramatically reduce the support for Medicare beneficiaries from the Federal Government. Dramatically. And as CBO has pointed out, by the

year 2030, you essentially flip the burden from where it is today. Today the Medicare beneficiary, on average, picks up about 30 percent of the costs and the Medicare program picks up about 70 percent. By the year 2030, under the Republican plan, it is the reverse, because of the rising costs of care and the diminishing support from Medicare. Double whammy.

And I want to just really wrap up with this point, because we have heard it said that what the Republican plan offers Medicare beneficiaries is really the same as what Members of Congress get. The reason that is simply untrue is because Members of Congress, by law, have a certain percentage of their health care premiums supported by the Federal Government, by the taxpayer. In fact, under what is called the Fair Share Formula, that ranges from 72 to 75 percent, on average, the share that is picked up by the Federal Government.

Under the Republican planned future Medicare, we are going to be asking essentially Medicare beneficiaries to pick up themselves that cost, and the Federal Government will pick up only the remainder; so essentially, the flip of the deal that Members of Congress give themselves. That is unfair.

We have to make choices. We have said many times on this committee, to govern is to choose. We have lots of members on our side who are not wild about every aspect of IPAB, even in its back-stop role. But I think we are united, and I believe ultimately the American people are united, that that is a better approach -- we have to fix the kinks as we go along -- than the idea of ending the Medicare guarantee and

throwing that decision, not to experts who are confirmed by the United States Senate as a back-stop, but the people on the front line will be the insurance industry. Under the Republican plan, it is the insurance industry that fixes the benefits, frankly, actually in consultation with, what you guys say, "Federal bureaucrats." And they will set the premiums and they will choose; not the patient, at the end of the day.

So that is the choice. Mr. Chairman, thank you for holding this hearing. And I look forward to the testimony.

Chairman Ryan. Thank you.

[The information follows:]

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Chairman Ryan. Madam Secretary, the floor is yours.

STATEMENT OF KATHLEEN SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary Sebelius. Thank you, Mr. Chairman. Chairman Ryan, Ranking Member Van Hollen, members of the committee, I appreciate you inviting me here today to discuss how the Affordable Care Act is strengthening Medicare for seniors today and tomorrow. My written testimony provides more detail, but I want to quickly highlight some of the steps we are taking as part of the health care law to fill the gaps in Medicare coverage, to improve care and make the program more sustainable for the future, while preserving its guarantees for seniors and for people with disabilities.

When Medicare became law in 1965 it served as a national promise that seniors wouldn't go broke because of a hospital bill. In 2006 the Medicare program added coverage for prescription drugs, which makes up a growing share of beneficiaries' health care costs. But we know that too many seniors still struggle to afford their medications, and that is why the Affordable Care Act provided relief to 4 million beneficiaries who fall, year in and year out, into the Medicare Part D doughnut hole with, in 2010, a one-time, tax-free check for \$250. And some of the beneficiaries who have written to me say they basically took that check and went right to the drug store to help pay a part of their bill. And this year, because of the Affordable Care Act, those

same beneficiaries are getting a 50 percent discount on covered name brand drugs. By 2020 that gap closes completely.

We also know that many seniors were going without the preventive care that can help actually prevent illness before it occurs, lowering costs and saving lives. And in some cases, they were doing that because of expensive copays, and that doesn't make a lot of sense. So beginning this year, the law allows Medicare beneficiaries to receive recommended preventive services like screenings for colon and breast cancer, as well as an annual wellness visit, without paying a copay or deductible. It is the right thing to do and it is the smart thing to do because it helps us catch small health problems before they turn into big ones.

The law is also helping to improve the quality and safety of care for people with Medicare. Now, we know that there are model hospitals across the country that have adopted best practices to dramatically increase the quality of care. In fact, for every common medical error, we have examples of health systems that have significantly reduced, even eliminated, them. And there is no reason why all Medicare beneficiaries shouldn't enjoy that same high quality of care wherever they receive it. And that is why the Affordable Care Act provides unprecedented support to help these best practices spread.

In March, we launched the Partnership for Patients, an historic partnership with employers, unions, hospital leaders, physicians, nurses, pharmacists and patients' advocates to reduce harm and error in our Nation's hospitals. Last week we were able to announce that more than 2,000 hospitals across the country have already signed up

and are taking steps to improve care aimed at two very important goals: reducing preventable readmissions and reducing hospital-acquired conditions.

Under the law, we have also established the first of its kind Medicare/Medicaid Coordination Office that Congressman Van Hollen referred to. The office is working with States to improve care for beneficiaries who were enrolled in both Medicare and Medicaid and often receive fragmented or duplicative care as a result. And through the new Medicare and Medicaid Innovation Center created by the law, we are testing a wide range of additional models for increasing the quality of care, from strategies for helping seniors manage their chronic conditions, to new models in which hospitals and doctors who help keep their patients healthy and out of the hospital can share in the cost of savings they create. Together, these reforms are dramatically strengthening Medicare today for seniors and Americans with disabilities.

But we also have the responsibility to preserve the promise of Medicare for future generations, and we can't do that if costs continue to rise unchecked. Because doing care the right way often costs less than doing it the wrong way, many of the law's reforms are aimed at improving care and reducing Medicare costs. For example, the Partnership for Patients alone, with those two pretty tangible goals, will save Medicare as much as \$50 billion over the next 10 years by reducing errors that lead to unnecessary care.

But the law doesn't stop there. It also contains important new

tools to help stamp out waste, fraud, and abuse in Medicare. For fiscal year 2010, our anti-fraud efforts returned a record \$4 billion to taxpayers, and these tools in the Affordable Care Act help us to build on that progress. The Medicare trustees estimate that these reforms in the Affordable Care Act have already extended the solvency of the trust fund until 2024. Without these reforms the trust fund would have been insolvent just 5 years from now.

But when it comes to Medicare's future, we can't take any chances, and that is why the law also creates the Independent Payment Advisory Board, or IPAB, as a back-stop, a fail-safe to ensure Medicare remains solvent for years to come. As you know, the IPAB is made up of 15 health experts, including doctors, other health care professionals, employers, economists and consumer representatives. Members are recommended by Congress, appointed by the President, and confirmed by the Senate. And each year, the Board is charged with recommending improvements to Medicare. The recommendations must improve care and help control costs.

For example, the Board can recommend additional ways for Medicare to reduce medical errors and crack down on waste and fraud. And contrary to what some have suggested, IPAB will not ration care or shift costs to seniors. In fact, the Board is specifically forbidden by law from making any recommendations that would ration care, reduce benefits, raise premiums, or raise cost-sharing or alter eligibility for Medicare. It leaves all final decisions in the hands of Congress.

If Medicare spending begins to threaten the program's future,

IPAB will make recommendations to create the necessary savings without shifting the cost of care to seniors and those with disabilities. But it is up to Congress to decide whether to accept the recommendations, or to come up with recommendations of its own to put Medicare spending on a stable, sustainable path. In other words, the IPAB recommendations are only implemented when excessive spending growth is not addressed and no other actions are being taken to bring spending in line.

Now, the nonpartisan Congressional Budget Office and the independent Medicare actuary both predict that the IPAB is unlikely to be necessary anytime soon, thanks to the work we are already doing to slow down rising costs. But we can't know about the future. And that is why experts across the country, including independent economists and the Congressional Budget Office, believe that IPAB is a needed safeguard, and we agree. We believe that the best way to strengthen Medicare for today and tomorrow is to fill the gaps in coverage, to crack down on waste and fraud, to bring down the cost of improving care. And that is what we are working to do, given the new tools in the health care law.

Over the last 16 months, our Department has focused on working with Congress and our partners across the country to implement the new law quickly and effectively. And in the coming months I look forward to working with all of you to continue those efforts and to make sure that Americans can take full advantage of all that the new law has to offer.

Thank you again, Mr. Chairman. And I look forward to our conversation.

Chairman Ryan. Thank you.

[The prepared statement of Secretary Sebelius follows:]

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Chairman Ryan. As I mentioned in my opening, I quoted the President, which I thought was pretty much head-on with his remarks about Medicare. The trustees, your chief actuary projects the trust fund goes bankrupt in 2024. CBO tells us it is in 9 years.

Do you agree with the President and Medicare's chief actuary that the status quo as we know it, the traditional fee-for-service system is unsustainable and will soon fail to deliver the promise of health and retirement security for seniors that we all depend on?

Secretary Sebelius. Well, Mr. Chairman, I believe that the fee-for-service system has incentives in all the wrong places, so we are often paying for care that actually delivers very poor health results. And in fact, in many cases, if people are sicker, stay in the hospital longer, acquire more infections, are readmitted more frequently, that hospital makes additional money, as opposed to preventive aggressive home-based, patient-centered care, which often is not only more desirable by the patient and doctor, but actually lowers the cost.

So the Affordable Care Act for the first time gives Medicare not only the tools but the direction to actually align the incentives and, I think, the payment strategies.

Chairman Ryan. Okay. So I think on the premise of that we would agree, which is the current system is unsustainable and has all the wrong incentives, which is part of the reason why it is driving it toward bankruptcy.

Secretary Sebelius. I would say that the current

fee-for-service system, yes, is unsustainable.

Chairman Ryan. So if you could bring up chart one, please.

So here is the question we have. I have got basically three questions. And this is, it is basically, you know, how best to solve this problem. According to your chief actuary, providers who are reimbursed through Medicare receive about 80 percent of what a private plan offers. And as we all know, what inevitably happens is, if a provider loses money on a Medicare patient, then they will overcharge the private payer to make up the difference. And that is putting upward pressure on prices, on health care costs. Under the health law, the Affordable Care Act, this falls from 80 percent to 48 percent by 2022, and to 33 percent by 2050.

Hospitals suffer the same fate. This is the hospital reimbursement rate curve under the new health care law. A 67 percent drop in prices relative to what private plans pay over the course of the window. So we are already paying them, providers, through Medicare, far less than they get otherwise. In most cases we are paying less than they actually -- the cost of the care.

And so basically, I have three questions. Do you agree with the chief actuary's findings that cutting payments to providers does have an effect on providers? Because here is what he says. He is saying that by the year 2050, 40 percent of hospitals, skilled nursing facilities, and home health agencies will have negative margins. In other words, they will go bankrupt. So that means they will leave the business of providing Medicare services to Medicare beneficiaries. Do

you agree that cutting payments to providers has an effect on providers in such a way?

Secretary Sebelius. Mr. Chairman, I do believe that certainly cutting payment has an impact. What I know is that Medicare cost trends are actually significantly, I would say, better than the private sector, growing at about 4.9 percent, as opposed to the private sector growth of about 7.2 percent over the last 10 years. And I do believe that Medicare has the opportunity to actually change the cost trends by improving the underlying costs of delivering health care, as opposed to -- I would suggest that the House Republican plan just shifts those costs onto seniors and those with disabilities and does not address the underlying costs at all. I think improving care and lowering costs makes a lot more sense than just shifting costs.

Chairman Ryan. Well, okay. So this is the hospital chart which shows, under the Affordable Care Act, reimbursements to hospitals goes down precipitously.

Go to chart two if you can.

That is the physician chart which shows Medicare and Medicaid obviously goes down precipitously under what private plans pay. So obviously, if we underpay them it is going to save more money. The question is, if we keep underpaying them at this pace, will they keep delivering the benefit? I mean, so our issue here is if there are fewer providers participating in Medicare, because their payments are going down so far below their cost -- we have 10,000 baby boomers retiring every day. Do you not agree that if we underpay them, that they will

just stop seeing beneficiaries?

Secretary Sebelius. Mr. Chairman, I think that assumption is that nothing changes in care. Nothing changes in the care trajectory, that we keep paying at the same -- not only rates, but keep paying for the same kinds of services. So if you assume that care delivery doesn't change at all, that we keep paying for good care the same as bad care, that we don't have any changes in underlying care, that we don't coordinate care, that we don't have more home-based patient-based care, that we keep the churning of one out of every five Medicare patients going in and out of the hospital, whether or not they have seen a health care provider or not, that trend line is probably accurate.

I would suggest that what the Affordable Care Act does, and what we have begun to do, I think pretty successfully in these early days with the innovation center and the very enthusiastic support of a lot of health care providers across the country, is look at where the best practices are, where the hospital systems are and the provider groups who have actually delivered very high-quality care, well below the trend line, and capture that; and then reach out to others to try and accelerate that change, and use the enormous payment levers of the Medicare system to do just that, to drive best practices.

Chairman Ryan. So we are right now looking at a law that will pay providers 80 cents on the dollar, then 66 cents on the dollar in this decade, going down to 33 cents on the dollar. So you are saying that we will be able to sort of mastermind how to pay for this care at those low rates and they will still provide these services? This

is where I don't understand this.

Ultimately, don't you believe that there is going to be a time where if you are going to so dramatically underpay for a service to a provider that they would provide a beneficiary, that they will just stop providing that service? I mean isn't that effectively rationing, in of and of itself? If you don't pay the providers anything close to what it costs to provide the service, won't they just stop providing the service?

Secretary Sebelius. Well, Mr. Chairman, again, I would suggest that what is going to occur, and is occurring across the country, is a different kind of service being provided, a different strategy around health care services, and one that actually suggests that doctors and hospitals, through mechanisms like the Accountable Care organization, actually group together around quality-care delivery and share in the savings that they achieve. We have heard from very enthusiastic participants around that strategy.

So I think if you capture the status quo and say you just drive that into the future and nothing ever changes, this is probably an accurate chart. But I don't believe that that is sustainable. I also don't believe, Mr. Chairman, that just taking those cost trends, shifting the burden of costs onto seniors and those with disabilities, which the plan that has been passed by the House of Representatives does, addresses this at all. It just means that more of those costs are going to be paid by seniors and those with disabilities. It doesn't bring more doctors. It doesn't change the underlying costs. It

doesn't deliver better care. It means that fewer and fewer seniors out of their own pocket are going to be able to afford the care they need.

Chairman Ryan. Can you bring up chart three?

Okay. So this chart shows you what we thought prescription drug law was going to cost originally. Actually, the CMS actuary estimated it was going to be about a \$700 billion, 10-year program. CBO, a \$400 billion program. It came in 41 percent below those cost projections, 41 percent below the CBO projections, which were \$400 billion, versus the CMS, \$700 billion projection.

And so I want to ask you basically this. Do you, if you had to do it over again, because at the time there was a debate between Republicans and Democrats about how to do the drug program. The Republican view prevailed at that time, which was to have Medicare certify private plans to offer drug benefits to seniors and each year they get to choose among competing plans for their benefit. And that active choice of competition, according to your actuary, accounts for 85 percent of the cost reductions or the savings from the projection. If you had to do it all over again, would you scrap the Part D program the way it is designed today and would you have gone with the original point of view that it should just be one program run by Medicare and not one of competing plans?

Secretary Sebelius. Mr. Chairman, I don't know that I could answer that question. I think there were a few fatal flaws in Part D that I certainly would go back and change. One was the design of

the program so that the seniors who got the most prescriptions fell into a coverage gap; and, secondly, it wasn't paid for. So one of the reasons that Medicare is becoming less solvent is that we have a huge unfunded liability in Part D.

Chairman Ryan. But the delivery system, would you have stuck with multiple plans that people can choose from, or would you have sided with the position at the time of your party that we should not have that, we should just have a one-size-fits-all, only Medicare provides the drug benefit.

Secretary Sebelius. As I say, I think there are some fatal flaws that have been corrected. I do think that the drug program is an essential benefit that many, many seniors rely on. I can't tell you the cost estimates of one versus many. I do think Medicare still pays for drugs at a higher price than anyone on Earth, and as a Governor who used to run a program where I negotiated for drug prices, I can tell you that they are still overpaying for drugs.

Chairman Ryan. Let me ask it this way. Should seniors be given a choice of plans to choose from to get their drug benefit?

Secretary Sebelius. I think that is a great idea. And seniors are given a choice of Medicare programs now with Medicare Advantage, and many have also some fee-for-service plans along with traditional Medicare. What we know, though, is that Medicare Advantage, the private market strategy, is still well above the fee-for-service strategy, and no beneficial health results as a result.

Chairman Ryan. Okay. I don't want to keep wasting time on this.

But you agree with the idea that seniors ought to have plans from which to choose from for their benefits; is that correct?

Secretary Sebelius. You tell me what we are looking at and what costs are -- I mean it is impossible to --

Chairman Ryan. I have been asking you about Part D the whole time. Should they have a choice of plans for their drug benefit?

Secretary Sebelius. As opposed to what?

Chairman Ryan. As opposed to the other idea of not having a choice of plans.

Secretary Sebelius. If it is 30 percent cheaper with the negotiated rate, probably that doesn't make sense. It is a choice. I mean, having drug benefits is critical and I would like to get seniors the drug benefit at the best possible cost.

Chairman Ryan. Okay. Here is the point we are trying to get at here. The health care law, the Affordable Care Act, ends the Medicare guarantee. It ends Medicare as we know it. It takes a half a trillion from Medicare to spend on the Affordable Care Act. It puts a cap on Medicare. And this is the first time we have actually capped an entitlement.

Now, nobody is arguing against capping spending around here. The only difference is, this law empowers the IPAB with the unilateral power to decide how to live underneath that cap. And where we have an issue, you mentioned affordable care organizations. There isn't a Wisconsin provider that is willing to sign up for this. The ACOs. What our concern is, if we invest all of the power and the funding decisions

with a Board of 15 people whose decisions go into law, don't even go through Congress, is that the best way to save this entitlement and to restrain spending?

We believe there is a better way, and we believe giving seniors the choice, like we did with Part D, is a better way, because what it does at the end of the day is it shows providers if you want to succeed, if you want to have business, you have got to outcompete other providers for that beneficiary's business. So the nucleus of the problem we are trying to take is the patient, the beneficiary, not the IPAB. And there is the big difference at the end of the day.

We really believe, because of evidence and reality, that giving seniors more choices, more providers, doctors, hospitals, insurance companies compete against each other for that beneficiary's business, that works.

More importantly, you talk about what this would do to future seniors. We think we should give more money to low-income people, more money to sick people than to wealthy people, in the future of Medicare. And if we do it in a way like we are proposing, you don't have to do all of this to the current population. You don't have to have IPAB start their indiscriminate price controlling in 2013, you don't have to do any of that. You don't have to affect benefits of people above 55, and we can cash flow and borrow the money to cash flow that generation if we reform our generation, those of us under 54. And the way in which we think we ought to do that, more money for the poor, more money for the sick and the middle-income and less money for the

wealthy. It is an idea that used to have bipartisan support. It is an idea that came out of the Clinton 1999 Bipartisan Commission to Save Medicare. It is a very good and legitimate debate to debate about growth rates and how you grow a payment and should it be GDP or GDP minus this or that. That is a very fair debate.

But at the end the day, where I think we have a disagreement is we don't think we should invest all of the power and money decisions into the hands of 15 people who aren't even elected, versus giving seniors the ultimate decision in controlling how their health care is to be delivered. Because if we just simply give 15 people the ability to unilaterally underpay providers, and we see where this is headed, what is going to end up happening is providers are just going to drop Medicare. I don't know what you call that, but it is rationing under a different word. Because if you say to a provider, we are not going to pay anything close to what it costs to provide that service, they are not going to provide that service.

Secretary Sebelius. Well, Mr. Chairman, first of all, IPAB, as you know, in the statute, doesn't come into effect unless Congress has not taken action. So Congress is in the driver's seat. Day one, IPAB makes recommendations if the spending trends are on target.

Chairman Ryan. What is the threshold? It is a supermajority vote to prevent that, though, correct?

Secretary Sebelius. Only if Congress has not preceded IPAB. I am suggesting that if Congress is actually paying attention to the bottom line of Medicare, IPAB is irrelevant coming up with good strategy

suggestions, and it never triggers in. That is step one.

I also would suggest, Mr. Chairman, that, you know, when I think about Medicare, I actually start with my dad who was in the Congress in 1965, sat on the Energy and Commerce Committee, helped to write the law. He turned 90 in March. And I can tell you he is a happy beneficiary, relies on those services, but really doesn't have the capital right now. If he were paying 51 to 70 percent of his costs, it starts at 61 to 70 percent of his cost, that is not flexible income that he would have available right now.

Third, I think that the notion of moving Medicare from guaranteed benefits, which is what we have said to seniors and those with disabilities, you will have a benefit package that you can rely on into the future; when you get sick you will not go bankrupt. Turning that over to private insurers and to an unelected group of Federal employees who design the benefit package and determine which benefits seniors will and will not get, I am not sure keeps the promise that we made.

I am all for looking at strategies to reduce costs. And I would suggest that we have really never done that seriously until the Affordable Care Act. We have never had the tools and particularly the tools to look at the underlying costs. Not just, you know, trimming off the top of providers, but really reengineering the delivery of health care. And most, a good number of health care providers who I visit across the country, say not only is it achievable, it is essential, and they are well on their way to doing just that.

Chairman Ryan. Well, I want to be -- I want to wrap it up because

I want to get to Mr. Van Hollen and the rest. I have been on Ways and Means for 12 years, on the Health Subcommittee. I have watched us try to reengineer Medicare over and over and over, from Republicans to Democrats. It never ends up working because it is kind of a fatal conceit. We sit in Washington and we think we can figure out how to micromanage 17 percent of our economy and make this all work. And all we end up doing is artificial price controls across the Board. That was what the 1997 budget agreement did. And we had all these providers going out of business. So we put the money back. I don't see how this movie isn't repeating itself.

Secretary Sebelius. Well, if Congress can't figure it out, private insurers are going to then figure out how to --

Chairman Ryan. So we already have private insurers delivering comprehensive Medicare benefits. They have shown that they will do it cheaper, less than we expected. We already have private insurers providing Medigap, providing Medicare Advantage, providing Part D. Actually you contract out with private insurers to do part A. And so that is something we have already had experience with.

What we also have experience with is if we simply underpay providers what their costs are, they stop providing. That we have experience with as well. And so I would just simply say at the end of the day, we have a difference of opinion on how best to achieve this.

My mom is on Medicare. Your dad is on Medicare. They have already organized their lives around this program as it is currently designed. Let's leave that alone. Our point is, don't change for that

for them. IPAB does. We are saying don't do that. But in order to cash flow this commitment that they have already organized their lives around, which we should, you have got to fix it for the next generation, and we just have a difference of opinion on how best to do that.

And with that, I will yield to Mr. Van Hollen.

Mr. Van Hollen. Thank you, Mr. Chairman and Madam Secretary, thank you for your testimony.

I want to pick up on a couple of lines of questioning that the chairman began, especially as they relate to cost shifting, because that is exactly what the Affordable Care Act addresses in many ways. When you have tens of millions of Americans with no health insurance whatsoever, and they show up at the hospital as their primary care provider, guess who pays? Guess who pays? Taxpayers pay. And consumers pay through cost shifting.

Now, we have heard from the chairman about the fact that Medicare actually gets a better deal in terms of the amount of payment to providers, and that is reflected in part in the fact that Medicare's per-capita growth rates have been less than in the private sector. That is because they are able to use their bargaining power.

What you are seeing with the Affordable Care Act are people who have no health insurance, not a penny. That was cost shifting going on. We were all paying in a big way. And by creating an exchange that tens of millions of Americans can participate in now and get their preventative health care, it means they are not showing up in the hospital. So it is not only good for the health of those individuals

and their families, but it is good for the pocketbooks of the rest of America because they were paying zero to the doctors and zero to the hospitals.

Now let's talk about another piece of cost shifting, because, you know, obviously, if you pay the doctor zero, you are going to shift costs. Well, if you shift costs, if you shift costs the way the Republican plan does, you are not saving a penny to the system. You are just moving those costs on to seniors.

I have right here the April 5, 2011, CBO analysis of the Republican budget plan. It says right here that under the proposal, most beneficiaries who receive premium support payments would pay more for their health care than if they participated in traditional Medicare under either of CBO's long-term scenarios. CBO estimated that in 2030 a typical 65-year old would pay 68 percent of the benchmark under the proposal, compared with 25 percent under the extended baseline scenario, and 30 percent under the alternative fiscal scenario. I would point out again to my colleagues that that is the flip of what Members of Congress get in terms of support, so-called premium support from all points.

Let me just if I could get through this, and I will be happy to answer your question. So that is the exact flip. That is cost shifting. Doesn't save a penny, and it actually reduces the amount of support.

Now, I want, Madam Secretary, you to expand upon another point here which, as the chairman mentioned, we already have some private

options, private insurance options within the Medicare program. It is called Medicare Advantage. It is called Medicare Part C. And the difference between the current system and what the Republican budget proposes is we allow the Medicare beneficiaries to choose whether they want to go into Part C or whether they want to stay under traditional Medicare. The Republican plan says no more choice. You are forced into the private plans. Now, the chairman mentioned what he described as the benefits of this compensation.

Madam Secretary, could you tell us what the rate that the Medicare program was reimbursing the so-called more efficient Medicare Advantage plans, compared to the traditional plans before the Affordable Care Act?

Secretary Sebelius. Yes. Congressman, Medicare Advantage plans were being paid at about 113 percent of fee-for-service. And what the Affordable Care Act directs is that over time, that additional payment, which amounts to about \$3.30 per month per beneficiary -- not the beneficiaries who have chosen the Medicare Advantage plan, that 25 percent -- but to every beneficiary is paying that additional amount per month every year to keep Medicare Advantage at that artificially high level. So over time, we are directed to reduce that overpayment and put it more in line with Medicare fee-for-service. And we have begun that, and, I would suggest, still have, we anticipate, a very robust program. But the overpayment is calculated by the Congressional Budget Office to yield about \$140 billion over the next 10 years.

Mr. Van Hollen. Right. And again, people can choose currently to go down that road. They are not forced to go down that road as the Republican budget plan would do. But they can choose it. And as you pointed out, we, meaning the taxpayer and the Medicare program, were subsidizing those plans at 114 percent of fee-for-service, meaning not only were taxpayers paying more for individuals in that plan through Medicare, but other Medicare beneficiaries were cross-subsidizing those plans; is that correct?

Secretary Sebelius. That is correct. And over the period of time, also, there has been a pretty careful analysis of were there additional health benefits that were attributable to the additional expenditure. And the answer is no.

Mr. Van Hollen. Right. Now, under Medicare Part C, under Medicare Advantage, there is a wide range of ability to experiment with copays and premiums and many of the tools that we are talking about; is that not the case?

Secretary Sebelius. There is opportunity certainly to experiment and to, you know, develop different plan strategies. There are limitations on how much those costs can be shifted on to beneficiaries and particularly how much the plan design could be used to cherry-pick among healthier seniors or sicker seniors. But given those limitations, yes, there is a lot of opportunity for innovative care strategies by the private market.

Mr. Van Hollen. Okay. Now, I just want to turn to Medicare Part D, the prescription drug plans, and ask you a few questions about that

because it is the case that the expenditures came in under projections. If you read the Medicare actuaries, they point out two major factors there. One was that the cost of prescription drugs in the overall market went down because of a competition from generics. And Number two, fewer people actually chose to enroll in Medicare part B than had originally been projected which, of course, would bring down the costs. But of course, one of the features of the prescription drug bill, Medicare Part D, when it was passed in 2005, was to deny the Medicare program the ability to negotiate or bargain for drug prices.

The other change that was made was that for people who were so-called "dual eligibles," people who were on Medicaid and Medicare, previously Medicare of course had not covered prescription drugs, but the Medicaid individuals had been -- we had gotten a better rebate, meaning a better deal from the prescription drugs companies than when those individuals also got prescription drugs under Medicare. Can you -- that is money that is lost to the Medicare program; is it not?

In other words, reduced drug prices for the Medicare programs represent savings that could be plowed into the Medicare program and extend the solvency of the program; is that not correct?

Secretary Sebelius. That is correct. And I think in most States around the country, the negotiation of drug prices, formularies, and rebates are something that most Governors take seriously with the Medicaid program, and that is not a framework that the Medicare program operates under.

Mr. Van Hollen. And if we could go to the fourth slide.

And we are going to have the Medicare actuaries here tomorrow. But this is an interesting point that they made in their most recent report which says the average annual increase in Part D per-beneficiary costs are expected to be greater than for HI, that is Part A Medicare, or SMI, Part B, for the period of 2011 through 2020. So Part D which, as the chairman said, has this competition feature, but where the bargaining for the price of drugs is splintered into subgroups as opposed to being able to get a better deal for the whole group, like we do under the Veterans Administration, but what this chart shows is that the Part D is actually expected to grow more per beneficiary than Part A and B. Could you comment on that?

Secretary Sebelius. Well, Mr. Chairman, I do think that trends in part are up because there are definitely some more expensive but very significant new drugs on the marketplace. And that will continue to be part of the framework. But I also think that there are some tools that we are still missing.

I know in the chairman's home State of Wisconsin, there is a senior care program which was negotiated, put into effect by the Governor, and is very popular with a lot of seniors in Wisconsin, and still operates as a stand-alone drug plan, which can be a choice for those seniors. And the costs that Wisconsin seniors pay for senior care is significantly below what Wisconsin seniors can choose from in Medicare Part D. So that we have a real-life example in the State where there is a State-negotiated plan, side by side with the Part D multiple choice plans, and the costs are, I would say, significantly different.

Mr. Van Hollen. Thank you. I am going to wrap up, Mr. Chairman, with a couple of slides. Just if we can go back one slide.

What this shows are the projected CBO costs in 2030. And again recognizing the fact that the Medicare program is able to negotiate better prices and bring down the cost, Madam Secretary, do you know what the average costs for a senior was for health insurance in 1965 before we passed the Medicare program?

Secretary Sebelius. The average cost per senior?

Mr. Van Hollen. The average cost for health care -- the distribution of costs born by the senior compared to the government or other sources.

Secretary Sebelius. Well, it is my understanding that first a number of seniors, a majority of seniors, had no health insurance at all. And secondly, that those who had insurance or some kind of coverage were often paying about 65 percent of their own costs and that there was some payment for the remainder at the time.

Mr. Van Hollen. So some had none at all, and some had to bear the burden that we would go back to under the Republican proposal. If we could go back one more slide.

This is the 2022 numbers. Again, it is the double whammy. It is the fact that seniors will go into the private insurance market and face higher costs and get less support in 2022, even though immediately the benefit the Secretary talked about with respect to closing the prescription drug doughnut hole goes away.

And then if we just go to the last slide, this is the Medicare

actuary showing how the Affordable Care Act does then prosper.

Thank you, Mr. Chairman. Thank you, Madam Secretary.

Secretary Sebelius. Congressman, one perspective on those cost issues is if you assume that there are a number of seniors in this country who are living on their Social Security checks, in 2022 the average Social Security check will be a little over \$21,000, and that beneficiary, with the start of the Republican Congressional plan, would be paying 59 percent of that Social Security check on their health care costs. That same beneficiary today pays about 26 percent of their Social Security check for health care. So it is a more than doubling what amount of their income would have to go to health care, year one.

Chairman Ryan. I want to get to members because we are going to start the clock. One thing we failed miserably on a bipartisan basis is to learn how to manage the thermostat in this room. Tell your actuary who is coming tomorrow that we are going to work on it.

Secretary Sebelius. I thought it was a strategy.

Chairman Ryan. Mr. Price.

Mr. Price. Thank you, Mr. Chairman. And welcome, Madam Secretary. We appreciate you joining us today.

Many of us, as you well know, and as a physician have talked about the principles of health care being accessibility and affordability and quality responsiveness to the system, innovation of the system, and choices for patients. And many of us believe that the new law actually harms every single one of these principles.

There is also little trust between patients and folks out there

in the Federal Government as it relates to health care. And for a variety of reasons, former Speaker Pelosi on this specific law said we have got to pass the law so we know what is in it. And this, the Independent Payment Advisory Board, a denial of care opportunity for the Federal Government, is one of the things that we now know that is in it. And it ought to be no surprise that there is little trust out there.

I will remind you, Madam Secretary, that the original Medicare legislation says in it -- and this is still the law of the land -- quote: Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or compensation of any officer or employee of any institution, agency, or person providing health care services.

Madam Secretary, do you think that we have violated that portion of the previous Medicare law that is still the law of the land?

Secretary Sebelius. Violated it by passing the Affordable Care Act? By --

Mr. Price. No. By having the Federal Government determine what compensation is provided to those caring for patients.

Secretary Sebelius. Congressman, I think that the Medicare from day one determined what compensation they would pay for services, medical services, so I guess I am not quite sure what we are doing. I mean, perhaps you are suggesting that from the outset, from 1966 it has been in violation.

Mr. Price. That we violate the law and hence there is little

trust on the part of patients. And this, the Independent Payment Advisory Board, this "denial of care Board" can only do that by denying payment to physicians. In a recent op-ed, you said, quote: Seniors and taxpayers will have the security of knowing that as skyrocketing costs jeopardize Medicare's future, IPAB is in place to protect Medicare now and for future generations. But in fact if we talk about the kind of recommendations that IPAB can make, are they able to reach different targets by raising revenue? Can the Independent Payment Advisory Board raise revenue?

Secretary Sebelius. No.

Mr. Price. Not by law. Can the Independent Payment Advisory Board raise beneficiary premiums?

Secretary Sebelius. Well, the IPAB as you know is prohibited by law from cost shifting, from premium increases, from denying benefits. I think there are a number of examples of ways that they could have been effective at a much earlier time. And one of them we just discussed, which is overpayment for Medicare Advantage.

RPTS BLAZEJEWSKI

DCMN HERZFELD

[11:05 a.m.]

Mr. Price. But, Madam Secretary, don't you agree --

Secretary Sebelius. Which was the situation with MedPAC for years.

Mr. Price. If I may, because I don't get the kind of time that the chair and the ranking member do. The only way that the Independent Payment Advisory Board are able to affect what the physician does for the patient is to deny payment for that provision of services; isn't that correct?

Secretary Sebelius. I don't think that is at all correct, Congressman. I think they could look at a lot of the underlying rising costs and recommend payment strategies that much more closely align what doctors tell me they really want to do. So medical homes where the patient --

Mr. Price. But they aren't able to institute any of that. All that they can do is deny care or deny payment to the physician.

Secretary Sebelius. I don't think that is the case, Congressman. I fundamentally disagree. Medicare Advantage --

Mr. Price. I would urge you, Madam Secretary, then, to simply read the section, just read the section.

Secretary Sebelius. I know it.

Mr. Price. If I may, this gets to the heart of the quality of

health care in this country. As a physician, I can tell you that if I am told by the Federal Government that I will not be paid for a service to a physician, what happens in my presentation of the options to that patient as that treating physician is that I may be coerced by the Federal Government into not even presenting that option to the patient. So this is as pernicious as it could be in terms of the Federal Government getting involved in the provision of care to patients, and that is what violates the trust that is so important between patients and physicians, and it is why we on this side of the aisle and some on the other side of the aisle feel so strongly, that to have a denial of care board in place in Federal law is simply a violation of American principles as it relates to health care.

Secretary Sebelius. Well, Congressman, I hear what you are saying. I would suggest that the Republican budget proposal, which would eliminate guaranteed benefits for which there will be --

Mr. Price. Madam Secretary, you know that is not true. You know that is not true.

Secretary Sebelius. Congressman, I think it is --

Mr. Price. The point of the matter is that our proposal guarantees --

Chairman Ryan. We have got to move to the next --

Mr. Price. -- the provision of care for seniors. It guarantees it.

Chairman Ryan. Let us leave it at that. End of your time.

Ms. Schwartz.

Ms. Schwartz. Thank you.

I would like to continue this conversation somewhat. This is important for us to be talking about what are the really big contrasts here, and the big contrasts when we are talking about the future of Medicare is what we are working on, what passed last year, which is now law, which I want to have you elaborate on, the work of implementing the Affordable Care Act and in strengthening Medicare and getting the best value for our dollars, and I want you to talk about that; but before we get there, to understand the choice that is being presented, the contrast with the Republican plan -- we used to call it the Ryan plan, but now that all the Republicans basically voted for it in the House, it is the Republican plan.

This is what the House of Representatives majority, the Republicans, want to do, which is to end Medicare as we know it, offer seniors premium support. We call it a voucher because they can get to shop in the private marketplace, which, as you pointed out, Madam Secretary, is more expensive and does not have the concerns about cost because they simply can raise the premiums, and the more they raise the premiums, the more seniors will have to pay. Estimates are about \$6,000 a year per senior, \$6,000 starting, \$6,000 per senior per year, going up to doubling that, and who knows what in the future.

The cost shift is directly to the seniors with no protections for those seniors, no consumer protections, no guarantees on benefits, and no offering them, I think, what the chairman would say is options. They can choose between expensive plans or plans that don't have all the

benefits they can afford. This is not what we want to see happen.

And in contrast, however, I want to say to my Republican colleagues who say that there is no trust in Medicare, most Americans and most seniors like their Medicare, and they want to see it continue, and so do we. So what I think is particularly interesting about what your testimony in this hearing is the very key focus for seniors in particular about strengthening the benefits and getting better value for the dollars that we spend in Medicare. We know we can do better in delivery of care, and I love some physicians. I actually care a lot about my husband, and my son, and my daughter-in-law and many of the physicians and hospitals that I know, and they are saying they know they can do better. They would like that flexibility; they would like the tools and the innovations to be able to do that.

In the Affordable Care Act we emphasize primary care, we wanted to train more primary care physicians, we wanted to pay them better under Medicare and Medicaid, we wanted to give physicians and hospitals real flexibility in redesigning better coordinated care for seniors in this country in order to provide better care, improve their health and their outcomes, and to save taxpayer dollars.

So I wanted you to give all that up, to repeal the Accountable Care Act as the Republicans want to and replace it with a voucher that seniors can use in the private marketplace that has had, unfortunately, not taken these kind of innovative actions the way they might have, but might well now do it in cooperation with what Medicare is doing.

Can you just elaborate on particularly the cost savings, the

potential in cost savings, based on the experience that we have already had and the good work that you are doing now in the innovation center with accountable care organizations, with patient-centered medical homes, with health innovation zones, with the reduction in hospital-acquired infections and reduced admissions? The opportunity, I understand, is really in the hundreds of billions of dollars in savings. What a better way to use that dollars to be able to reinvest and keep Medicare strong.

Secretary Sebelius. Well, Congresswoman, you are absolutely right, and I think we have just started down the path. In addition to the innovations, and I will talk about those in just a second, I think the new tools that Congress gave us and directed us to use for fraud and abuse are unprecedented, and I think that can yield also some significant dollar savings.

We have just started the predictive modeling computer effort, and I can guarantee you it is going to be very impressive in terms of results. But the innovation center is just launching some of the strategies. The Partnership for Patients we have talked about, which really is aimed at two simple goals to start with, but many more to follow. That is about \$50 billion. That is a -- according to the CBO, a conservative estimate if we can get more people to participate, lowering hospital infections and preventable readmissions, and that not only helps people in the Medicare system, but anybody who goes into the hospital. If there are fewer infections that people get in the hospital, it is going to help private employers, it will help people --

Ms. Schwartz. The whole point is to reduce the rate of growth of costs across the board. We certainly will thank you.

Chairman Ryan. We would like to get in as many people as possible.

Is Mr. Chaffetz here? No, it is Mr. Stutzman.

Mr. Stutzman. Thank you, Mr. Chairman, and thank you, Madam Secretary, for being here today.

I want to touch on the progress of IPAB. And the health care law provided \$15 million in fiscal year 2012 to get IPAB up and running. CMS is required to begin calculating the savings targets in 2013. What progress have you made toward setting up the IPAB as a functioning agency?

Secretary Sebelius. Congressman, that work has not started. I think the President is consulting with possible candidates for the IPAB Board, but there is no setting up an agency before there is a board appointed.

Mr. Stutzman. Do you know, are there any qualifications to be sitting on the Board?

Secretary Sebelius. Yes. The statute lays out a series of areas of expertise which the Board should have, very similar to what MedPAC Board members currently have, health care providers, health economists, consumer advocates, people experienced with health finance. I think a key difference between the Board qualifications for IPAB and the Board qualifications for MedPAC are no conflicts of interests. If they are to be an appointed member of the Independent

Payment Advisory Board, it must be a full-time assignment and not be an active user of the system or receive payment from the system.

Mr. Stutzman. So they will sit -- it will be a full-time job; is that correct?

Secretary Sebelius. That is the way the statute is.

Mr. Stutzman. Any idea what salaries would they be paid?

Secretary Sebelius. I think it is the same as -- I know it is equivalent of a Federal salary. One hundred sixty thousand dollars? I don't know what it is -- but it is a level that is a Federal -- I don't know if it is a Federal judge or -- I don't really know, I am sorry, Congressman. I can get you that answer.

Mr. Stutzman. Okay. Could you please elaborate on the claim that this year's House-passed budget, the Republican plan, if fully implemented would make it so cancer patients would die sooner? Wouldn't a lower quality of care caused by cutting provider payments in half cause patients to die sooner?

Secretary Sebelius. Congressman, I think I was at a hearing where I was asked what happens if someone runs out of money in a voucher in the midst of a chemotherapy program, and I said, frankly there aren't a lot of options. Charity care is one, donated care is another, or they just stop taking their cancer therapy and would end up --

Mr. Stutzman. Let me ask this --

Secretary Sebelius. That was my answer.

Mr. Stutzman. Okay. My granddad just passed away, and I have seen how Medicare worked for him. The average couple turning 65 today

pays -- paid over \$109,000 into Medicare over their lifetimes, but they will receive over \$343,000 in benefits. As a 34-year-old, and many others who are not even close to the age of 65, will I get the same deal?

Secretary Sebelius. I think it depends on what Congress decides to do with Medicare in the future.

Mr. Stutzman. Could I get the same deal? At the current levels, if we would stick with the Democrat plan, if we would stick with doing nothing, could I get the same deal?

Secretary Sebelius. Well, no one has suggested doing nothing, Congressman. I think that the Affordable Care Act actually took a major step for the first time ever in entitlement reform, and gave us tools at the Centers for Medicare and Medicaid Services to finally align payment with high quality, lower-cost care delivery, and we are trying to accelerate that pace.

Mr. Stutzman. But what I don't understand is what the affordable health care plan did was addressed insurance.

Secretary Sebelius. No, that is not true. It addresses insurance, but also the care delivery system. It addresses the underlying system in addition to insurance.

Mr. Stutzman. So do you believe that health care costs will start declining? Because currently they are roughly at three times the rate of inflation.

Secretary Sebelius. Well, actually they have been on a decline. They are right now running lower than inflation. We think that if,

indeed, the strategies are effective where you focus more on preventive care and early intervention, where people are actually healthier as they get to be 60 and 70, you can dramatically improve health care costs, as well as some care strategies which are aimed at delivering more patient-centered care out of hospital systems, keeping people in their homes longer, which is what patients tell me they want, and also what a lot of providers would like to do, but right now the alignment of the payment incentives and the care delivery are not there.

Mr. Stutzman. I think that, you know, with these numbers, if \$109,000 covers \$343,000 in benefits, Americans understand that this is not going to be sustainable over the next --

Secretary Sebelius. Well, I would agree, and everybody agrees with that.

Mr. Stutzman. -- decade. It is going to take some big changes.

Secretary Sebelius. That is right.

Mr. Stutzman. Thank you. I will yield back.

Chairman Ryan. Mr. Blumenauer.

Mr. Blumenauer. Thank you, Mr. Chairman.

Madam Secretary, thank you. I would like to just briefly touch a few things.

As I listen to my good friend, the chairman, describe certain things, I wondered if we were talking about the same bill, because certainly you were talking about a very different bill than I heard him talk about.

My understanding is that you testified -- and I just picked up

a copy of it again just in this section -- that the provisions here do not -- are not triggered by the IPAB unless and until Congress does not deal with escalating costs in Medicare. Is that correct?

Secretary Sebelius. That is correct.

Mr. Blumenauer. That is the bill you are talking about?

Secretary Sebelius. That is correct.

Mr. Blumenauer. If we fail to act, don't get a spinal implant, then they can make recommendations, and it says right here, not rationing, not shifting, but in terms of helping, in terms of delivery mechanisms, but those go into effect only if Congress -- and Congress has the ability to overturn those provisions. Is that not correct?

Secretary Sebelius. That is correct.

Mr. Blumenauer. That is the bill you are reading?

Secretary Sebelius. That is the law.

Mr. Blumenauer. I listened to my good friend from Georgia talk about what appeared to me to be sort of a fantasy land because he was concerned that Medicare over the years has had some provisions about Medicare reimbursement. Now, my good friend, as a private physician dealing with private insurance, and you have been an insurance commissioner, you are knowledgeable about this, do physicians just willy-nilly submit anything they want, and insurance companies just pay every provision, every condition, every treatment?

Secretary Sebelius. No. Rates are negotiated, and benefits are very clearly spelled out.

Mr. Blumenauer. And do insurance companies ever push back and

deny claims?

Secretary Sebelius. Regularly.

Mr. Blumenauer. They do?

Secretary Sebelius. Yes, sir.

Mr. Blumenauer. Okay. I just wanted to get that clear because I thought that was the case.

And so what we are talking about here is just simply being able to have the same sort of provisions that happen in the private sector, except my friends on the Republican side would just turn this all over to insurance companies to do the rationing, the denial, the approval, and seniors will navigate on their own. That is a statement; you didn't have to answer that.

I heard you take my good friend Mr. Ryan's point here that somehow the \$373 billion cost, which represents less than what was projected, was somehow a grand bargain for Medicare Part D, and you started to point out something in terms of there were other ways of doing it. Could you -- I don't want you to do it now. I don't think you should do the math in your head, but I think it is a very serious question. Could you have some of your certified smart people calculate for us what would have been the cost in 2030 if we just gave our senior citizens the same deal that the veterans get?

Secretary Sebelius. We could do that, sir.

Mr. Blumenauer. I suspect that it is probably quite a bit less --

Secretary Sebelius. I have a lot of certified smart people.

Mr. Blumenauer. -- than the \$373 billion that my friend is so

excited about. Would you think it might be less for the veterans than what was negotiated?

Secretary Sebelius. I would think it is substantially less, yes, sir.

Mr. Blumenauer. I think it would be good for us just to get those numbers, because, again, I am concerned that we are talking about a fantasy world where insurance companies don't make decisions denying benefits, don't ration care, don't cut people off; that somehow that the -- because the prescription Medicare drug program, unfunded, just sort of launched, did not -- was not as expensive as it first projected, that somehow that is a triumph of free-market economics when, in fact, we could produce much lower costs with systems that the government has, and that we have an actual experiment about the cost-effectiveness of this approach with Medicare Advantage.

I am old enough to remember when Medicare Advantage was advanced in the early -- because it was going to save money. It was going to be 5 percent less, 95 percent on the dollar was the projection, and because the system was gamed or of inefficiencies, it has been 13 percent more expensive until recently, because of the changes that have been put in place to bring it under control, and all the while seniors are paying a premium. What did you say the extra cost was a month, \$3?

Secretary Sebelius. I think it is \$3.30 per month per beneficiary, and there are about 49 million beneficiaries.

Mr. Blumenauer. Thank you very much.

Thank you, Mr. Chairman.

Chairman Ryan. Mr. Ribble.

Oh, before you start, it is my understanding that the Secretary has to go in 10 minutes, so we will get through this, and then what we will do is we will start the Members who did not have an opportunity yet to be at the top of the queue for the next panel.

Mr. Ribble.

Mr. Ribble. Thank you.

Madam Secretary, thank you for being here today. I know it is probably not the funnest thing you do in your workday.

Secretary Sebelius. It certainly is the warmest.

Mr. Ribble. Yes, it is the warmest, and it is a warm greeting that we extend.

Secretary Sebelius. I appreciate that.

Mr. Ribble. Under the Affordable Health Care Act, I think I understood that we can't deny care; is that correct?

Secretary Sebelius. The Independent Payment Advisory Board --

Mr. Ribble. No, not the Independent Payment Advisory Board, but under the Affordable Care Act, the denial of coverage is protected by law, you cannot deny coverage; is that correct? I get to keep my insurance company, and I get to keep my doctor, and I can't be denied coverage and things like this?

Secretary Sebelius. Well, eventually when there is, in 2014, the health exchanges set up, you will be able to have an ability to come into a market without preexisting health conditions, yes, sir.

Mr. Ribble. And once I am in that market, the health insurance cannot be denied to me if I get sick?

Secretary Sebelius. That is correct, you can't be dropped.

Mr. Ribble. Can't be dropped.

Secretary Sebelius. Rescissions are against the law. Companies dropping a beneficiary because they made a technical error, because they got sick, you cannot have that.

Mr. Ribble. And that is done through private insurance companies through the exchanges?

Secretary Sebelius. That is correct.

Mr. Ribble. Okay. So kind of like the Republican plan for seniors; private insurance companies, can't be denied coverage, and if they get sick, they get to keep it?

Secretary Sebelius. Well, I think a huge change is that the cost sharing is shifted to seniors and those with disabilities under the Republican plan. There is no plan for underlying delivery system changes, there is no fraud and abuse protections, and I have no idea what the benefit package looks like. Maybe there has been a discussion, but at least I have not seen what the \$8,000 voucher would purchase in the marketplace.

Mr. Ribble. And since we can't see all that yet, it just seems a little bit disingenuous for my colleagues on the other side of the aisle and members in the administration to project all these salacious claims about the plan since we haven't yet seen it.

Secretary Sebelius. Well, we are projecting costs, and that is

not us, it is the Congressional Budget Office, which says that a senior would be paying 61 percent of his or her costs starting in year 1 and closer to 70 percent by year 8. That is the Congressional Budget Office, that is a flip of --

Mr. Ribble. And the CBO shows a large high cost, don't they?

Secretary Sebelius. Pardon me?

Mr. Ribble. And the CBO shows a relatively high cost.

Secretary Sebelius. That is based on today's costs.

Chairman Ryan. Will the gentleman yield? We asked the CBO about that. They basically said that they can't estimate choice and competition in effect, and so they didn't bother trying. So, number one, they don't -- they can look at --

Secretary Sebelius. They can look at Medicare Part D.

Chairman Ryan. But they can't measure it.

Secretary Sebelius. They can look at the cost increases in Medicare Part D, and they can certainly look at the cost increases in Medicare Advantage, so we have two real-life examples of cost.

Chairman Ryan. The point is they looked at the example in Medicare Part D in the savings, and they did not replicate that in their cost estimates of this plan. They just ignored it.

Mr. Ribble. Thank you for the clarification, Mr. Chairman.

Madam Secretary, during the testimony today regarding IPAB, you said that -- not only in your written testimony, but in comments you said that they are prohibited from cost shifting, premium shifting, payment denial, rationing care, raising premiums, reducing benefits,

changing eligibility. I think you mentioned that they are going to be paid something for their work, you don't really know how much, but yet you call them a backstop. If they can't do any of these things, what are they backstopping?

Secretary Sebelius. Well, let me give you two examples, Congressman, about the kinds of things that, if they had been enacted a lot sooner, I think we could have saved billions of dollars. We have just discussed Medicare Advantage, the overpayment which has gone on for decades, and actually the MedPAC group, the group of advisors has recommended looking at that strategy, lowering it to fee-for-service for years. That has never happened.

The other thing that has recently happened, and again Congress started down this path as long ago as 2003, is our recent experience with competitive bidding for durable medical equipment. It started in 2003, it got a jump start in 2008, it was withdrawn again. This year we have implemented in one of the Medicare sections, we are saving 32 percent over the cost we were paying last year for durable medical equipment. There is no change in beneficiary benefits. They are getting the services they need, but at a third of the cost.

I think those are two kinds of recommendations that don't fall into any of the prohibited categories that could yield billions of dollars.

Mr. Ribble. Okay, thank you very much.

Mr. Chairman, I am going to yield back to give my colleagues more time.

Chairman Ryan. Mr. Yarmuth.

Mr. Yarmuth. Thank you, Mr. Chairman.

Secretary Sebelius, it is nice to see you again. Thank you for your testimony.

I want to pursue this line of questioning about competition and the effects of competition, particularly as it relates to health care. Doesn't the ability of competition to -- or the potential for competition to reduce costs depend on a fully informed, fully free negotiation on both sides?

Secretary Sebelius. Usually that is what a market strategy is.

Mr. Yarmuth. And with regard to Medicare Part D, I think certainly virtually everyone had the same experience I did, that my constituents for a long time were extremely confused, and many still are confused, about what their choices are under the prescription drug program. Is that likely, assuming that we were to enact the Republican proposal, that this would be an enormous problem for America's seniors to actually be in a position to intelligently compete with the insurance companies' approach at marketing?

Secretary Sebelius. Well, Congressman, what we have done, at least in the last 2 years, in some of the Medicare Part D programs, we have also done it a bit in Medicare Advantage programs, is try to eliminate programs that actually have very little differential, but just add more confusion to the marketplace to do just that.

But, yes, I think it is not uncomplicated. We used to run a senior Medicare counseling program, and many people want to make the best

choices. They often, though, in Part D would find themselves in a program, the drug regimen would change in that program only to find out that the drugs that they need have actually shifted out of the program. So that is a pretty common phenomena for seniors.

Mr. Yarmuth. And so then if you add benefits for hospitalization, physician choice, home health care, medical equipment, and potentially hospice, and who knows what else, it makes it an extremely, even more complicated way for -- complicated procedure for a senior to go through, a senior and his or her family to go through.

Secretary Sebelius. Well, I definitely think that there is a huge ongoing effort to educate folks about what the benefits are and how to take the best advantage of them.

You know, one of the points we haven't really touched on, but I do want to mention, is just the additional cost of administration. Most insurance companies, even the most efficient ones, run at about 11 to 13 percent. Some are as high as 25 percent. Medicare has about 2 percent or less administrative costs. So assuming you have X amount of dollars, a fixed contribution, whatever that fixed contribution can buy in health benefits, less of it is going to go pay for health services in the private market than in the public market.

Mr. Yarmuth. And granted that the Republican proposal has not been put into legislative language that we could actually look at, but if you consider the statements that have been made from the other side that nobody can be turned down, that nobody can be denied service, and nobody can be denied the choice of the physician under the Republican

plan, do those stipulations make it much more difficult for insurance companies then to actually lower costs?

Secretary Sebelius. Well, again, insurance companies, you know, to my knowledge, have a network of doctors, so they do accept some and deny some on a regular basis. They negotiate with hospitals. Some are in, some are out. They negotiate with drug -- I mean, that is part of the strategy to put a plan together. And then when you buy that insurance, you are buying basically that network, that hospital system, that group of providers. It is, I think, a different system than Medicare currently, which says to a patient, you can choose any doctor you want. If you don't like this doctor, you can go to a different doctor. That is not the strategy around private insurance.

Mr. Yarmuth. I guess what I was trying to get at, judging from what has been said from the other side about the Republican proposal, is it likely that they could have a significant impact on overall cost to the system if they can't deny care, they can't deny anyone coverage, and they can't -- and they have to provide all the services that Medicare provides?

Secretary Sebelius. Well, if you assume that insurance is about selling a product which delivers health care, pays providers, pays hospitals, pays doctors, you know, there are only a limited number of ways that you can reduce costs. You can reduce administrative costs; you can negotiate better prices with all the payers and providers, which is reducing costs; you can aim at better health strategies, which I think can be effective, get a healthier population. I think often in

the private market currently that is done by cherry picking. We take healthier people and deny sicker people, so the pool is healthier. You make money that way. But there are a limited number of strategies. Or you can shift costs. And I would say that both the Medicare and Medicaid proposal that passed the House shift costs onto seniors, those with disabilities onto States.

Mr. Yarmuth. Thank you.

Chairman Ryan. Madam Secretary, I wish we had more time to get into all of this. I obviously have a strong difference of opinion of your interpretation of what we are doing, but I don't think you like our interpretation of what you are doing. This is an issue we are going to have to get into in much more detail. It affects nothing more than the health care security of our Nation's seniors. We have a strong difference of opinion on who ought to be in charge of their health care, them or this Board. I wish we had more time to get into it. The Members who have not yet had the opportunity to ask will be front of the line for the next panel. And with that, Madam Secretary, I know it was a hot morning. Thank you for your indulgence. I appreciate it and hope we can do this again.

Secretary Sebelius. Thank you, Mr. Chairman.

Chairman Ryan. Thank you.

Chairman Ryan. Next we will hear from our next panel. If the panel can proceed to the dais, go ahead and take your seats so we can get started.

Our second panel consists of former CBO Director Doug Holtz-Eakin, Grace-Marie Turner of the Galen Institute, and Judith Feder. Is it Feder?

Ms. Feder. It is Feder.

Chairman Ryan. Feder, thank you. It is one of the two. Judith Feder of the Urban Institute.

Because we have votes, it looks like at about 1:20, we are going to stick to the 5-minute rule for our panelists, so if you could confine your opening remarks to 5 minutes, and then we will do the questioning, as I mentioned earlier, and if there are additional points the panelists want to interject, they can do so during the questioning.

Let us start with you, Mr. Holtz-Eakin, and then we will work our way from our right to left, your left to right. Thank you, Mr. Holtz-Eakin.

**STATEMENTS OF DOUGLAS HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION FORUM;
GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE; AND JUDITH FEDER,
Ph.D., PROFESSOR AND FORMER DEAN, GEORGETOWN PUBLIC POLICY INSTITUTE
AND URBAN INSTITUTE FELLOW**

STATEMENT OF DOUGLAS HOLTZ-EAKIN

Mr. Holtz-Eakin. Thank you, Chairman Ryan, Ranking Member Schwartz, members of the committee. It is always a good day to be back at the Budget Committee, and I have my written testimony. I won't belabor the points.

There are four simple points I think ought to be made. The first is that, to my eye, the IPAB is a policy error and one that the Congress should reverse as quickly as possible. It is likely to exacerbate existing reimbursement problems for providers in the Medicare system, and as a result impede access by Medicare beneficiaries. It is likely to stifle innovation. The incentives are such that it will target the most innovative and newest therapies, and the IPAB, as part of the status quo for Medicare, is dangerous to beneficiaries, dangerous to the Federal budget, and dangerous ultimately to our economy because it is part and parcel of a broken social safety net system whose spending threatens to drive debt to levels which would harm the U.S. ability to compete and grow.

Let me expand on those only briefly, and then turn it over to

questions. The structure of the IPAB is such that it is likely to exacerbate the reimbursement problems. The way the statute is written, much of Medicare spending is off limits, so the Board is likely to have to target something that looks like less than half of the total spending, and thus disproportionate efforts would be focused on that.

The IPAB is given 1-year targets, says you have to get things under control in a year. There aren't many levers you can pull from a proactive quality-of-care or value proposition that you can do on a 1-year basis, and in the end they will start cutting provider reimbursements. It is something we have seen before with the SGR. It is something we will see again. We know vividly from the Medicaid program, where reimbursements are just a bit over half of private payers, that beneficiaries have a great deal of difficulty getting access. That would be the future of Medicare as well more broadly. We have seen, for example, with past episodes in cuts to the physicians under the Medicare program, the SGR, that fully two-thirds of practices have contemplated as changes in their access for Medicare beneficiaries whether they take new patients or not. So I think that is an outlook under the status quo that is dangerous for beneficiaries and dangerous for the American health care system.

It is quite likely to stifle innovation. We know at some fundamental level that innovation is at the core of the ability of the United States to solve its pressing problems in health care, in energy, in education, and a variety of policy areas. Given that there will be a mandate to cut spending, the most likely targets are those new

therapies, the ones that are just introduced in the market. They have been expensive to develop. They have not yet reached economies of scale. These are going to be the newest, most innovative approaches to things like Alzheimer's and the problems that face us, and the IPAB will have a disproportionate incentive to stifle those.

From the perspective of someone who is developing the therapies, the IPAB is a tax on the return to these, you are not going to get a return on your investment, and worse it is a random tax. You don't know when it is actually going to pop up and grab the return to your investment. So it will have terrible incentives for the development of new medical science in the United States and, as a result, harm the future quality of care. And then it is part -- this focus on trying to cut provider payments and control a broken fee-for-service Medicare system is part and parcel of the status quo that I think we simply have to change in a fundamental way.

We know that these important social safety net programs -- Social Security, in red ink, unlikely to survive to the next generation; Medicare, enormous buckets of red ink, \$280 billion a year in general revenue flowing in, not going to be -- to survive for the seniors in the next generation; Medicaid, the future deserving poor will be unable to receive its services, and in the process they are feeding the deficit problems that this Congress has to grapple with and the Budget Committee is so well aware of -- we know ultimately that is not simply a budgetary issue, that is an economic threat of the first order. Erskine Bowles, co-Chairman of the President's Fiscal Reform Commission, called it the

most predictable crisis in history.

So the issues that are before us today are whether we will take a policy approach which has led to us being on the precipice of a disaster, or whether we will fundamentally change the structure of the Medicare program and the social safety net. And I would encourage this committee and the Congress as a whole to take the latter approach and to discard this policy error. Thank you.

[The prepared statement of Douglas Holtz-Eakin follows:]

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Chairman Ryan. Thank you. Within 12 seconds. Great.

Ms. Grace-Marie Turner.

STATEMENT OF GRACE-MARIE TURNER

Ms. Turner. Thank you, Mr. Chairman, Mr. Van Hollen, members of the committee.

There is no question that Medicare spending must be constrained if we are going to have any hope of getting overall Federal spending under control, but clearly there is a wide diversity of opinion about the wisdom of using the Independent Payment Advisory Board as a tool. It was designed to take difficult decisions about Medicare payment reductions out of the hands of consumers and legislators and delegate them to this panel of 15 independent authorities, but the Constitution gives the power of the purse to Congress so that elected Representatives can be accountable to the voters in their decisions. The IPAB would turn this principle upside down.

The unelected IPAB members will ultimately determine spending policies that will determine whether millions of seniors have access to the care they need. This challenges the very principle of representative democracy and the consent of the governed. The IPAB is at the center of a conflict between two world views. Do we entrust doctors and patients with decisions, or do we entrust those decisions to a government-appointed panel of experts in Washington who will have authority over hundreds of billions of dollars in Medicare spending?

The government approach to holding down Medicare spending traditionally defaults to making deeper and deeper reductions in payment rates to providers rather than implementing reforms that reward innovation. The legislation is true to form. And perhaps during the question and answer we can talk a little bit about some of the government's experiments so far in innovation and how those have turned out.

Because of the directives written into the law, reductions achieved by IPAB between 2013 and 2020 are likely to be limited primarily to Medicare Advantage, and to Part D prescription drug program, and to skilled-nursing facility services. If the Board is forced to reduce overall Medicare spending by focusing only on these relatively smaller segments, the cuts would have to be very deep to achieve overall per capita spending reductions. Because any of these moves could have major repercussions on access to care, it would seem that seniors and taxpayers would be much better served if these changes were to be openly debated through the legislative process rather than imposed by unelected officials.

Even before the IPAB cuts began, Medicare actuaries found that large reductions in Medicare payment rates already built into law would likely have serious implications for beneficiary access to care, as the chairman described in his opening remarks. The President would double down on these savings by giving the IPAB even more authority to cut payments to achieve his deficit-reduction goals. It is hard to justify further cuts in Medicare provider payments.

I will skip a little bit.

Clearly repeal is the best solution to begin to get us on a path that can move toward a 21st century health sector. Part D shows us the way. We have a working model that shows that when private companies compete, and, importantly, when seniors choose, that you can get costs and spending down both for seniors and for taxpayers. The average monthly beneficiary premium for Part D coverage will be \$30 in 2011, far below the \$53 a month forecast originally. Eighty-four percent of Part D enrollees are satisfied with their coverage and 95 percent say their coverage works well.

But looking beyond IPAB and looking beyond Part D, Chairman Ryan has proposed a comprehensive plan to modernize Medicare that builds on the Part D model. The key is premium support, which provides seniors with an annual subsidy to purchase a guaranteed Medicare health plan. When it begins in 2022, seniors would receive an age-adjusted allocation so they can pick the health plan that meets their needs, just as 11 million seniors already have done voluntarily through Medicare Advantage.

Premium support allows for flexible subsidies that can be adjusted and targeted to seniors based upon their age, financial well-being, health status, and similar considerations.

To survive, Medicare must be changed, and the question is whether it will be under IPAB and the rationing built into the President's health care law or through Chairman Ryan's plan that provides a path to sustainability for Medicare. It is a clear choice between this and

the top-down approach that puts a small number of independent experts in charge of decisions that will impact tens of millions of seniors and progressively limit their access to care.

Thank you, Mr. Chairman.

[The prepared statement of Grace-Marie Turner follows:]

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

Chairman Ryan. Dr. Feder.

STATEMENT OF JUDITH FEDER

Ms. Feder. Thank you, Mr. Chairman, and Ms. Schwartz, and members of the committee. Glad to be with you today to discuss the role of IPAB, which I believe serves as a guarantor of the ACA, the Affordable Care Act's, investment in assuring all Americans quality care at lower cost.

As you consider the role of IPAB, I call your attention to the fact that Medicare is an enormously successful program, more successful than private insurance, in pooling risk and controlling costs. Medicare has historically achieved slower spending growth than private insurance, and the ACA extends its relative advantage. Action taken in the Affordable Care Act produces an average annual growth rate of 2.8 percent per Medicare beneficiary for the years 2010 to 2021, 3 percentage points lower than national health care spending. National health spending is projected to grow about 2 percentage points faster than GDP growth per capita, and Medicare's projected per-beneficiary spending growth will be a full percentage point lower than per capita GDP.

Growing slower than the private sector is good, but not good enough, since both the public and private sector are paying too much for too many services and failing to assure efficiently delivered quality care. That is why the Affordable Care Act goes beyond

tightening fee-for-service payments to pursue a strategy of payment and delivery reform and creates the IPAB to assure effective results.

The strategy includes payment reductions for overpriced or undesirable behavior and bonuses or rewards for good behavior, most especially through payment innovations that reward providers for coordinated, integrated care efficiently delivered. These reforms have the potential to transform both Medicare and, by example and in partnership, the Nation's health care delivery system to provide better quality care at lower costs.

I have been kind of amazed to hear how little confidence there is in the capacity to reform the overall system and what these achievements of these savings cannot be assumed. That is why the IPAB exists, to recommend ways to achieve specified reductions in Medicare spending by changing the way Medicare pays health care providers. In essence, IPAB serves to inform and assure congressional action to keep Medicare spending under control.

Now, we know that some have proposed eliminating, repealing the IPAB, but along with about 100 health policy experts who recently wrote congressional leaders in support of IPAB, I see that effort as sorely misguided. As we wrote, the IPAB enables Congress to mobilize the expertise of professionals to assemble evidence and to assure that the Medicare program acts on the lessons of payment and delivery innovation the Affordable Care Act seeks to promote.

I would contrast the ACA's strategy to strengthen Medicare with the alternative strategy not only to repeal IPAB, but also to eliminate

Medicare for future beneficiaries, replacing it with vouchers for the purchase of private insurance, Vouchers, I would call to your attention, that are set taking into account all of the reductions in Medicare payment that we have heard criticized this morning. The CBO analysis shows that such an act will not slow health care cost growth, it would increase the cost of insurance and shift responsibility for paying most of them onto seniors.

Given Medicare's track record relative to private insurance in delivering benefits and controlling costs, morphing Medicare into the private insurance market simply makes no sense. Rather than go in that direction, what we should recognize is that Medicare is clearly doing its part to control costs, having reduced spending per beneficiary considerably and well below that in the private sector. But it can only go so far, as you have noted, on its own to promote efficiencies without partnership with the private sector.

Health care spending growth is not fundamentally a Medicare problem, it is a health care system problem. Effective payment and delivery reform requires an all-payer partnership to assure that providers actually change their behavior, that we do not go on as we have gone, rather than looking to favor some patients over others or to pit one payer against another. Rather than moving to abandon IPAB which supports Medicare's continued and improved efficiency, I urge you to modify IPAB's current spending target to apply not just to Medicare, but to private insurance, indeed all health care spending, and extend its authorities to trigger recommendations for all-payer

payment reform if the target is breached. It is all payers promoting efficiently that the Nation very much needs.

[The prepared statement of Judith Feder follows:]

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Chairman Ryan. Dr. Feder, I appreciate that very pure statement.

Ms. Feder. Well, and I appreciate your appreciation, Mr. Chairman.

Chairman Ryan. With that, we are starting with Mr. Flores.

Mr. Flores. Thank you, Mr. Chairman. I would like to thank the panel for joining us today. I believe IPAB has a Federal flaw built into it, but before we do that, I am going to try to hit some questions quickly.

Dr. Holtz-Eakin, you started your comments talking about the insolvency of Medicare and Medicaid. Can you give me what your perception of those metrics is?

Mr. Holtz-Eakin. All right.

Mr. Flores. If you looked at Medicare-Medicaid as a private-sector pension plan.

Mr. Holtz-Eakin. We know that Part A of Medicare is running a cash flow deficit right now. Parts B, C, D were never set up to be on their own footing, so they have always counted on what looks to be 79 percent of general revenue. So we have something well over \$250 billion, probably close to \$280 billion, flowing in out of general revenue to keep the program alive. That is now and it is going to get worse.

Mr. Flores. If you look at the infinite time frame.

Mr. Holtz-Eakin. It is by March.

Mr. Flores. My understanding is that Medicare is insolvent to the tune of about \$60 trillion; is that about right?

Mr. Holtz-Eakin. These are games that budgeteers play. Let me give you the sad fact. Medicare grows so quickly that there is no interest rate from which you can actually do a discounting exercise that will cause it to convert, so it is infinitely, infinitely underfunded by any sensible piece of arithmetic. You can only get a number --

Mr. Flores. So more than \$60 trillion?

Mr. Holtz-Eakin. You can only get a number if you assume a miracle occurs somewhere in the future and health care costs grow more slowly.

Mr. Flores. Right. We are going to get to that in just a second.

And Medicaid is somewhere in the neighborhood of 15- to \$20 trillion, right?

Mr. Holtz-Eakin. Yeah.

Mr. Flores. And those numbers together are five times our current national debt.

Mr. Holtz-Eakin. Huge.

Mr. Flores. Okay. One of my very first economics professors taught me that the laws of economics are like the laws of gravity. The worse you violate them, the harder the impact at the end, and that is essentially what we are in right now. If you look at what has been claimed to be the benefits of IPAB, it says that we can cut costs to providers, but yet not ration health care. So my question for Secretary Sebelius was going to be if we cut the budget for HHS by two-thirds, would she still continue to be able to provide the quality

response to her missionary requirements? And I would assume her answer would have been no.

My next question to her would have been if we were to cut the pay for the typical HHS employee by two-thirds, how many young people would want to enter that profession? And so I will ask whichever person on the panel wants to answer, if we cut the pay for doctors by two-thirds, how many young people as they are going into college are going to make the decision to go pre-med and then to follow through all the way through their residency program to become doctors? Anybody want to answer that?

Mr. Holtz-Eakin. I don't know the number, but the incentives are clear, and we have seen this movie before. We have been through this exercise where we say to the beneficiaries, you can have all the medical science you want at low or no cost, and then it costs an enormous amount. So we go to the providers and say, no, no, no, stop that, either literally don't cover that service, or we will cut the reimbursement.

Mr. Flores. The same thing is going to happen in the technology area. We are going to improve Medicare through technology.

Mr. Holtz-Eakin. And we are going to make the same mistake, the same mistake.

Ms. Feder. May I comment?

Mr. Flores. Right. There will be less investment in the industry because there is less money going into the industry to go forward.

One of the things that is caused -- one of the claims that is been

made by government, by Madam Secretary, was that Medicare's costs have grown at a rate slower than that of the private insurance market, and I can tell you firsthand as somebody who was in business for 30 years before I came here, the reason for that is we began to clamp down on what government health care plans would provide, and all of those costs shifted to the private sector. Does anybody disagree with that?

Mr. Holtz-Eakin. No.

Ms. Feder. Yes.

Mr. Flores. I was there.

Ms. Feder. So was I.

Mr. Flores. I watched my premium increases go up every year.

What caused that in the private sector?

Ms. Feder. The private sector has been far less aggressive than Medicare in attempting to limit health care costs.

Mr. Flores. So the government invented the HMO or the PPO?

Ms. Feder. Actually the government did invent the HMO in the 1970s in the Reagan administration. They actually promoted that policy, and they developed from that point, that is correct.

Mr. Flores. Let me correct you, though. It came from the private sector.

I don't see how we are going to make this work. We are going to cut pay to the people that provide medical care by two-thirds, and we are going to expect them to stay in the business.

Ms. Feder. May I comment on that?

Mr. Flores. Sure.

Ms. Feder. As I said in my testimony, what I think is there is an assumption that the Medicare system stays the same as it is, that there is no way to improve productivity in the system. The health care industry is the only sector in which we have not seen productivity increases, and, in fact, what the -- and I see the chairman nodding. The capacity to achieve productivity increases by delivering health care more efficiently, getting rid of unnecessary readmissions being a primary example. It is out there as a strategy that we all need to pursue and is being pursued by the public. The public is leading. Private payers are doing that as well.

Chairman Ryan. We will let that continue. I want to get to everybody.

Mr. Pascrell.

Mr. Flores. Thank you.

Mr. Pascrell. Thank you, Mr. Chairman.

And to add to what the good doctor just said, there were and are three promising models to cut costs and improve quality. If you don't believe in that, then you don't believe in the reform that was passed. One is the accountable care organizations. You have heard those terms, you have heard the discussions about that. Value-based purchasing programs. Very few places have done that. Where it has been done, it has been successful. And payment bundling, which is very, very critical, and a lot of places don't want to do that, do they, Doctor?

So there are many sections. Section 3001 to section 3009 and section 3020 to section 3028 deal very specifically with some things

that were not scored by CBO which I believe are going to bring a tremendous amount of -- look, when it comes down to it, Doctor, here is where we are at. Democrats want a guarantee benefit program. The other side does not. Regardless of how you slice it, that is what it comes down to. They are entitled to their opinion. I say that with deep respect.

But I want to talk about rationing. Rationing. We have heard that term. It came out the first couple of weeks when we started to discuss health care reform. We want to ration. You know, that is when it led to those cryptic remarks about we want to push Aunt Tillie off the cliff so we don't have to pay attention to her anymore.

So let us talk about rationing, Mr. Chairman. Over 50 million people in our country are uninsured. Kaiser Foundation, I think, has given us some good figures on that. Twenty-five million are underinsured. We see that in the letters I get, calls I get in my congressional office. I am sure the other guys and gals do the same thing. People cannot afford the care that they deserve and need. They can't do it. Rationing. As you all know, two-thirds of all personal bankruptcies are due to health problems. Rationing.

Just because you have insurance doesn't mean you are covered. We all know that, right? You could get diagnosed with a disease, your doctor could prescribe a comprehensive treatment for you, but if your insurance company says no, what do you do? You call your Congressman. You have little power against the insurance company, and that is what this is all about, Doctor, don't kid yourself.

Just look at all the requests that we get. Am I correct -- let me ask you, Ms. Turner, am I correct that this kind of rationing exists under private plans?

Ms. Turner. People are making choices and decisions all the time about limited resources, both in their financial capacity as well as the capacity of the market to deliver.

Mr. Pascrell. You can make a choice if you can afford it, if you are given the ability to make that choice. Not everybody can make the choice unless there are options in front of you, options that you fit into, and you don't have to worry about the person who is offering the options saying you don't qualify, or you have this disease and we are not going to cover you. Isn't that rationing?

Ms. Turner. We have --

Mr. Pascrell. Isn't that rationing?

Ms. Turner. We would not have a functioning market in our health sector --

Mr. Pascrell. Mr. Chairman, is that rationing?

Ms. Turner. People should have more choices. And the market would provide those choices.

Mr. Pascrell. Thank you.

Is that rationing, Mr. Chairman?

Chairman Ryan. Does the gentleman want to yield his time?

Mr. Pascrell. Sure.

Chairman Ryan. I think let us try to get the quorum. Having the government deny care to seniors through providers I would count as

rationing.

Mr. Pascrell. Okay. Would you agree with that, Ms. Turner?

Ms. Turner. Having the government deny care to seniors through a payment policy would also be rationing, yes, sir.

Mr. Pascrell. How about if insurance companies deny care and coverage to a young couple 40 years of age with three children?

Ms. Turner. Absolutely. And we need to reform the system so they have more choices and own that insurance.

Mr. Pascrell. Thank you.

Ms. Turner. So they can make their own choices in a competitive marketplace.

Mr. Pascrell. Thank you. Thank you.

It is all choices, but if you have choices out there, real choices.

I yield back, Mr. Chairman.

Chairman Ryan. Okay. I would simply say at least you can fire your insurance company. If you only have the government providing your benefit, you can't fire your government.

Mr. Pascrell. If you have someone else to take the place of that insurance company, yes.

Chairman Ryan. That is why we are going to fix this problem, we are going to fix the insurance market, we are going to fix health care.

Mr. Pascrell. Well, the Health Care Reform Act is going to do that, Mr. Chairman.

Chairman Ryan. We respectfully disagree.

Next we have Mr. Mulvaney.

Mr. Mulvaney. Thank you, Mr. Chairman.

As a limited government conservative, it is sort of hard to even know where to start to look at the Health Care Act. I heard Mrs. Sebelius in her testimony just a few minutes ago talk about where she starts when she looks at it, and she said she starts with her father. That got me to thinking about where I start, which is I start with my -- I have three sixth-graders, and as I listen to the list of everything that has supposedly happened, all these wonderful things that have happened so far. We have had this magical \$250 check go out to all of the seniors right before the election. We had this 50 percent discount now on name-brand drugs. We have got free annual wellness checkups. All I could think of as she was listing those things was who is paying for it, because it is my kids.

RPTS SMITH

DCMN NORMAN

[12:05 p.m.]

Mr. Mulvaney. And that probably drives my inquiry here. And I think it is interesting that these three sixth graders, have started to read a little bit of Orwell. They have read Animal Farm. They are getting ready to read 1984. And it struck me in Secretary Sebelius' testimony she used some words that I think mean different things to different people. She talked about the IPAB, which y'all have talked about as a back-stop or a fail-safe. And I have no idea what that means. I think I know what it might mean. What I think it means is that it is a committee that is set up to do what the administration wants to do if Congress won't do it on their own. And all of her testimony, I think, was partially correct when it came to the IPAB. You heard her talk about the process, about the IPAB would make recommendations on the growth rates, but that the final decision would go to Congress. Maybe. Not exactly true.

In fact, what she didn't say was that IPAB would make the recommendations, and unless Congress either approved that or came up with another way to save the same amount of money or have the same amount of impact, those recommendations would become law. Those recommendations would become law. In fact if Congress, all of Congress, got together and unanimously, Republicans and Democrats, said we don't want to do what this Board just did, that recommendation

would still become law.

She also accurately said a part of what the IPAB cannot do. You heard Mr. Pascrell just a few minutes ago talk about the fact that the IPAB is prevented from rationing. They are also prevented from making recommendations to lower -- to reduce services or deny coverage or that type of thing.

But here is what they can do. They can, as Mr. Holtz-Eakin suggested, they can recommend reductions in payment for services. In fact, it is one of their primary tools. And this example, while an extreme example, is entirely legal under the law. The IPAB could come out and say, as of next year, the reimbursement rate for a fee replacement is \$1. And that is going to save X number of dollars. And unless Congress comes up with a different way to save that \$1, then that becomes the law. That becomes the reimbursement rate for knee replacements. And in the event that happens, and doctors stop providing knee replacements for a dollar, then I think there would be a reduction of services.

It is interesting, I think to Mr. Pascrell's point, in the bill, the law goes out of its way to make sure that a reduction, a recommendation to reduce reimbursements, to reduce payments, is not to be deemed rationing. So the IPAB is given the ability to lower those payments, even though it has the effect of rationing coverage.

And I see that Mrs. Feder is disagreeing with me. I will tell you that we talked to CRS actually about that example and it turns out that it is absolutely right. So here is what we have got. We have

got this Board that is in charge of innovation, and I am getting to my question, Ms. Feder, and so I will leave it to you. We have got this Board that is in charge of innovation. We have got this Board that is going to be in charge, or could easily be in charge, of up to 20 percent of our economy.

So my question is this: Can someone please -- and you get the first chance -- give me an example of where that has ever worked in the history of mankind?

Ms. Feder. I think that we rely on independent boards which have varied records. We rely on a Federal Reserve to manage the banking system. We have got some ups and downs at that one of late. We rely on an Interstate Commerce Commission. We rely on a number of commissions.

Mr. Mulvaney. Does the Interstate Commerce Commission have the right to make law without Congress' approval?

Ms. Feder. I don't think so, but I am thinking that if I go to you with the Fed, the Fed makes a lot of rules for the banking system, so let me stay there. And what I think is important here -- and I do disagree with some of the aspects -- I think that some of what you said was not quite accurate because Congress -- if everybody in Congress doesn't like the recommendations they can reject them.

Mr. Mulvaney. Only if they come up with another alternative that saves the amount of money.

Ms. Feder. Sixty votes in the Senate can reject it. But my point is -- could I just finish? My point is that what I believe that the

Board does for the Congress is give you a source of expertise and tee-up the issues that need to be addressed. And I think that Secretary Sebelius gave us examples of the kind of things they could do, whether it is the -- they could promote a patient safety initiative, they could promote better payments, more efficient payments. So I think that there is a tremendous good they can do in bringing expertise to the Congress.

Chairman Ryan. Ms. Feder, you will have to leave it at that.

Ms. Moore.

Ms. Moore. Thank you so much, Mr. Chairman. I am a little bit interested, Mr. Holtz-Eakin, in this miracle that you were talking about in terms of reducing the trillions of dollars in liability that Medicare faces. And I do agree with you that there is an unfunded liability and how you might reconcile this. You say that you stipulate that health care costs, in general, not just in Medicare, must grow more slowly, which is something I have been harping on continuously. It is not just Medicare, it is the larger health care costs that must grow. But you say that the IPAB is dangerous, that it would stifle innovation. And so I guess your suggestion is that we shouldn't limit the cost in the growth of innovation; that that would be -- and you know, we do need innovation. And this, the IPAB targets that.

And many of us allege that, yes, this huge gap between the cost of innovation and all that will be borne by seniors; that this trillions of dollars -- if you would support, for example, the Republican plan for Medicare -- would target seniors.

So I am asking you to respond to how you see us limiting the cost of health care and also maintaining innovation. I am a little bit more interested in the miracle.

Mr. Holtz-Eakin. So I think fundamentally that the key defect of Federal health programs, Medicare and Medicaid particularly, the Affordable Care Act will be this way, is that they don't impose any budget on those programs whatsoever. They are open-ended draws on the taxpayer, with little incentive for useful adoption of innovations, efficiency, and coordination of care, or any of the things that everyone recognizes would improve the American health care system. And so I am --

Ms. Moore. So to some extent, you are agreeing with the Affordable Care Act reforms in terms of --

Mr. Holtz-Eakin. It doesn't do anything. There is no budget constraint put on anything here. All it does is say again, as we have done in the past --

Ms. Moore. But budget restraint, you are not wanting to restrain innovation. So the restraint would come where?

Mr. Holtz-Eakin. I realize there is a vigorous debate in both sides of this community about the House-passed budget. But among the things that a premium support plan would do is it would cap the taxpayers' liability --

Ms. Moore. The taxpayers but not the patient, who are also -- they are not taxpayers anymore because they are retired.

Mr. Holtz-Eakin. That is one. We both know that fundamentally

to be successful, health care costs must grow more slowly. You must stop the overuse of --

Ms. Moore. Okay. Thank you. I am hearing you say that these trillions of dollars have to be paid for by folks who are no longer taxpayers; they are retired.

Mr. Holtz-Eakin. That is not what I said.

Ms. Moore. Well, that is what it sounds like. I will ask Dr. Feder. We heard Secretary Sebelius, we heard the actuary -- was it the CMS actuary, Mr. Chairman -- say that the Affordable Care Act reforms could generate savings. But he was skeptical that there was the political will to execute them. I am wondering if you think that the IPAB would be an enforcement mechanism that might -- he stipulates that we could recognize savings if there were an enforcement mechanism.

Ms. Feder. Well thank, you Congresswoman. What I indicated in my testimony is that I think that what the IPAB does, it acts as a back-stop or guarantor to make sure that the innovations that are in the Affordable Care Act, that we are -- many of them untested and under development, which may have been what the actuary was talking about, that those actually take place, or that the improvements in demands or accountability for improved productivity for providers, which may have been what he was referring to --

Ms. Moore. I am going to give you a minute so that you can help Mr. Holtz-Eakin out, because he said that I mischaracterized what he was saying. You know, you guys are all experts in health care, and I am not. I was interested in the miracle of paying for these higher

health care costs without sticking it on seniors, and so he talked about needing innovation, and yet and not stifling innovation, but slowing the growth of health care. How would you --

Ms. Feder. Well, I am not sure what he meant, and I am sure Mr. Holtz-Eakin can speak for himself, as I have heard him before do. But what I believe is that the innovation that moves us away from a payment system that continues to reward forever more, ever more expensive services without regard to benefits for health needs to be replaced with an accountable system that rewards providers for delivering quality care, actually pays docs better.

Ms. Moore. And not death panels, right?

Ms. Feder. By no means death panels. We never have been and are not talking about death panels.

Ms. Moore. Okay. I just want to use my last 6 seconds by saying, I want innovation. I want new technologies available to seniors, but I do think that there has to be some shared payment for the system and not to pass trillions of dollars of costs onto retired seniors.

Thank you, Mr. Chairman, for your indulgence.

Chairman Ryan. Thank you. Ms. Black.

Mrs. Black. Thank you, Mr. Chairman. And having been a nurse for over 40 years and being in the health care system, I think there are a lot of things that we could do to reform health care. And we had a great chance to do that and we missed our chance.

But let me go back to IPAB, because as an elected official and also someone who believes in the Constitution, I believe that this IPAB

is a very, very serious breach in what Congress should have the authority to do. So there is unprecedented power here to an unelected Board. And I really believe that it is misnamed because it says it is an Independent Payment Advisory Board. But it is not just advisory. It has muscle. It has strength.

And where I have the concern about this is, currently the law says that the Independent Payment Advisory Board will kick in with its recommendations looking at Medicare growth at GDP plus 1 percent. The President has also come out and said that he believes that we need to lower that even to a half percent. Secretary Sebelius was here just a bit ago, and she made a great deal of emphasis on the fact that Congress has the ability to be able to make these recommendations before the Board kicks in.

But let me go to why I think that is a really misinformation piece, is that currently GDP is growing at somewhere between 3 and 4 percent. And I think I am right on that. Medicare is around 7 percent. And if we have got such a low threshold of saying GDP plus 1 percent, IPAB is going to kick in pretty quickly. And when they kick in and they give these so-called recommendations, they are not just recommendations. My understanding is that they are indeed going to be law, or make changes to the way we currently operate, unless there is a two-thirds override, which is a very, very high standard. And we all know how difficult it is to get two-thirds for anything, unless it is naming a Post Office.

So I have a real problem with that, in addition to the problem

with transparency and how this Board is going to operate behind closed doors without public opinion, public comment, and so on. What I would like to hear from each of the members of the panel here is, do you believe that there is a constitutional problem with having a Board making decisions that are going to become law without them being elected officials?

Mr. Holtz-Eakin. I am not a constitutional lawyer, but I do think it is at odds with conventional congressional practice and allocation response to oversight. And I find it troubling from that perspective alone. I am also a bit mystified by some of the other discussion about it. So there has been the notion that somehow it is just a bunch of the smart people who will give ideas for payment systems reform to the Congress, and then you guys will take care of it. There exists such a group. It is called MedPac. I serve on MedPac. It is where they send old CBO directors to die. And if it is just a matter of advice, this brings nothing new to the table, and thus will replicate the failure of MedPac.

There is also the notion that it guarantees other successes in the bill. That is not true. I mean, let us stipulate for a moment that the Center for Innovation at CMS will actually do something. I am skeptical, but let's suppose it really does. There is nothing that it can think of that they can put into rulemaking, get implemented, and actually produce results in a year. Those are big changes in payment systems, delivery systems. Everyone knows those are important. They aren't going to happen in a year. So in fact, IPAB

is structured to squash any unlikely success you get out of the Center for Innovation.

So I think it is at odds with conventional practice from its setup. I think it is internally inconsistent throughout its claim to the Affordable Care Act, and that is why I think it is a deep policy error.

Ms. Turner. I do think that IPAB goes further than any legislation, any Board in my experience. And it has not only the ability to have the force of law, but there is no administrative or judicial review. And provisions go into effect unless Congress reaches extremely high hurdles in overruling it, and then, as we have discussed earlier, having to achieve the same target. And I think that that makes an important point, in that the CBO has already shown it is not going to score quality improvements as really showing meaningful savings, especially in the 1-year time frame that the IPAB has. And so its only tools really are going to be more cuts in payments on the existing fee-for-service system. And we know where that goes and we know where that leads as far as payment rates and access to physicians.

So I think the miracle that Ms. Moore was talking about earlier is Part D. We know that the marketplace competition consumer power will get prices, costs, down for government programs and that must be the way we go.

Chairman Ryan. Ms. Wasserman Schultz.

Ms. Wasserman Schultz. Thank you, Mr. Chairman. I think we need to recap. Let's compare Medicare for seniors under the Affordable Care Act and Medicare for seniors under the Ryan Republican plan that passed

as part of the Republican budgets.

Under the Affordable Care Act, the doughnut hole is closed over 10 years. The actual, not magical check, Mr. Huelscamp, of \$250 that seniors received last year paid for actual groceries, paid for -- excuse me, Mulvaney. You are sitting behind Mr. Huelscamp's nameplate. Forgive me. The actual \$250 check, not magical, pays for actual groceries, pays actual mortgage, is actual money. So to suggest that somehow the \$250 check is mythical or magical or nonexistent is completely false.

I have stood in front of numerous town hall meetings of my constituents, asked for a show of hands of how many seniors got a \$250 check last year, and plenty of actual hands go up.

The 50 percent cut in name-brand drugs, the gentleman wonders how it is paid for. I will remind the gentleman that the entire Part D prescription drug plan was never paid for by the Republicans and added \$400 billion to the deficit over 10 years, and \$7 trillion to the deficit over 75 years.

So when it comes to who makes sure that we reduce costs in Medicare, who made sure that when we passed new policy that we ensured that it was paid for, Democrats did so, and preserved and protected and extended the life of Medicare, and Republicans jeopardized it.

In addition, the Affordable Care Act adds preventative screening like mammograms and colonoscopies that used to have a copay before the Affordable Care Act passed and that now are free, which means that we shift the focus in Medicare from a sick-care system to a wellness and

prevention system. And we ensure that seniors can stay healthy and we save health care costs down the road, because if they get screenings up front then they are less likely to get sick down the road. A wellness check-up, which was not something seniors were entitled to before the Affordable Care Act, a free annual wellness check-up, now they are entitled to that, again, being able to preserve their health rather than having them access the health care system for the first time once they are already sick, which we know would increase costs.

And so let's look at the Republican plan. The Ryan Republican plan to end Medicare as we know it gives a voucher to seniors and leaves them to the whims of the private insurance companies to get health insurance on their own, and adds \$6,000, actually more than \$6,000, to the bill of Medicare beneficiaries of seniors, all in the name of making sure that we can preserve tax breaks for millionaires and billionaires.

So Dr. Feder, if I can ask you, as you know, we have had some discussion this morning about the IPAB and what it can and can't do. It is explicitly forbidden from recommending any changes in premiums, any changes in benefits or eligibility or taxes or other changes that would result in rationing. So through those prohibitions, the IPAB can't increase Medicare or beneficiary premiums or cost sharing at all. They can't decide to just tell someone, tell a doctor that a knee surgery is a dollar and that that is the end of the story. So accuracy is important.

Do you agree with the assessment that seniors could face higher

out-of-pocket costs as a result of the Republican Medicare plan? And could you respond to my comparison of the two approaches to how we preserve Medicare and make sure we bring down costs and protect seniors?

Ms. Feder. Thank you, Ms. Wasserman Schultz. I do agree with your assessment, and let me give my interpretation of how that occurs. As I indicated, the voucher that is in the Republican budget is set, taking all the reductions in payment growth that we have talked about into account, that -- has all been accepted by Republicans in the House -- and gives a budget, then, gives a dollar amount for seniors to purchase private insurance, which the Congressional Budget Office says is already more expensive than the Medicare plan for seniors, and will be much more expensive in 2022 when the voucher is expected to start.

What that means is we are sending seniors on their own, will be sending seniors, myself included, on our own to shop for benefits without the ability of having the government behind us to negotiate or set prices on our behalf, determine that the benefits are what they ought to be. So it is simply a cost shift, that according to to the Congressional Budget Office, actually increases costs to seniors.

Ms. Wasserman Schultz. And would you say that -- it sounds to me like there is no debate over those facts, and those facts are in evidence.

Ms. Feder. I have not seen any evidence.

Chairman Ryan. Mr. McClintock.

Mr. McClintock. Well, following up on the question of

jeopardizing Medicare, Mr. Holtz-Eakin, can you tell us what are the projections actuarially for the bankruptcy of the Medicare system on its current course?

Mr. Holtz-Eakin. The Medicare system as a whole is bankrupt now. I mean it simply cannot pay its bills on a cash flow or a projected basis. So a trust fund for Part A, one tiny little piece, is expected to be exhausted in a bit over a decade.

Mr. McClintock. So continuing down the road we are on right now, which is basically the Democratic approach, assures the destruction of Medicare as we have known it or have ever known it.

Mr. Holtz-Eakin. I couldn't agree more. The status quo is dangerous to the beneficiaries, to the budget, and to the economy. And we have to change direction.

Mr. McClintock. One thing scaring a lot of the folks in my district who are on Medicare is they are beginning to feel trapped. They are finding it harder and harder to find doctors who will take Medicare patients. They are having to travel farther and farther when they find those doctors. Do you have any -- that is anecdotal. What is the data on that subject?

Mr. Holtz-Eakin. Well, the latest survey data that I have in my written testimony suggests that two-thirds of physician practices are reviewing their treatment of Medicare beneficiaries. And some of them will be aggressive enough as to not take any new beneficiaries. Some are contemplating it. But each time we go through an episode with both the sustainable growth rate and now the Affordable Care Act promise

to cut provider payments, they react in a very sensible business fashion. They say, We can't afford to do this. And they don't.

Mr. McClintock. So someone has turned 65. They have to give up their insurance for Medicare. They are now trapped in the Medicare system. They are finding it harder and harder now to find a doctor who will treat them. What is their alternative? What can they do if they can't find a doctor who is willing to take the Medicare reimbursement rate, or have to travel an exorbitant distance to find that doctor?

Mr. Holtz-Eakin. Pay out of pocket 100 percent of the cost, which is exactly the dilemma that Ms. Wasserman Schultz was highlighting.

Mr. McClintock. Mr. Stutzman put his finger on the subject, I think, when he pointed to the study that an average couple earning about \$89,000, retiring at 65, will have paid into the system about \$110,000 and will take out an average of over \$350,000. I don't think you have to be a Secretary of HHS or even a Member of Congress to know that that system is not, it cannot be sustained.

It seems to me that there are two ways to address it and those two ways are basically laid out in the approaches of the parties. One of them is price controls, the other is competition. Would you agree with that?

Mr. Holtz-Eakin. I do agree with that. I believe that my worst day as a CBO director was when a Member of the other body asked me what the right price for inhalation therapy was in Alabama. And that is

everything that is wrong with the Medicare system, and this continues it.

Mr. McClintock. That would also explain why we are now seeing a shortage of doctors. I mean we have got a lot of experience with price controls. They date back in written records as far as Hammurabi and they seem to produce very consistent results. They will, in every case I have ever studied, you know, Diocletian to Nixon, they will produce a shortage of whatever it is that you are controlling the price on. Do you know of any exceptions to that?

Mr. Holtz-Eakin. No.

Mr. McClintock. So we have a mechanism that we know will create a shortage. We are already watching it create a shortage. And we have now established an Independent Payment Advisory Board whose principal tool to hold Medicare costs down is to place more and more Draconian reductions into the price controls that are already there, meaning a more and more difficult time for people to find doctors, until you simply can't find them.

Mr. Holtz-Eakin. As I said, that is my deep fear is that this will accelerate what is already broken about the Medicare system, and that is something we can't afford to do.

Mr. McClintock. How would you describe the Republican approach to controlling these costs?

Mr. Holtz-Eakin. The approach is I think quite sensible in that it gives a finite amount of resources to a problem; and people, when they have a finite amount of resources, use it efficiently. It allows

the best package of insurance benefits at the right price to be selected by the Medicare beneficiary, thus rewarding value, which is how we have been successful in the other 87 percent of the economy.

Mr. McClintock. So it is basic competition. Will and Ariel Durant, in their History of Civilization, asked the question, What makes Ford a good car? Chevrolet. The fact that there is somebody there competing to offer better services at a lower price.

But just in the few seconds I have left, the hit on that that we keep hearing is, well, Medicare Advantage works that way and it costs more. Could you address that very quickly?

Mr. Holtz-Eakin. I believe that is a very mistaken statement. Medicare Advantage, when it is a managed plan, is cheaper and offers a better value proposition. The fee-for-service Medicare Advantage plans cost a lot because fee-for-service is broken medicine, regardless of the label attached to it.

Chairman Ryan. Thank you. Mr. Lankford.

Mr. Lankford. I want to get a chance to follow up on --

Chairman Ryan. I apologize, Mr. Lankford. It is Mr. Van Hollen. He didn't have a chance this round.

Mr. Lankford. Glad to yield.

Mr. Van Hollen. Thank you. Thank you, Mr. Chairman. Thank you. Let me thank all the witnesses.

And I want to just very quickly on the Medicare Part C, we know from CBO and the facts that we had been subsidizing that at about 114 percent of Medicare fee-for-service. But really what I want to

do is pursue the line of conversation that Mr. McClintock raised, because you, in your testimony, suggest that it is like really, really hard to find a doctor on Medicare. We just heard that anecdotal evidence suggests it is harder to find doctors. And I think we should all agree that rather than rely on anecdotal evidence, we should just look at the real evidence out there. And, fortunately, a nonpartisan group called MedPac that advises the United States Congress does exactly that survey.

And let me report to you what their most recent findings are because I think it is very -- it is informative on this issue. They talk about how every year they conduct a patient survey to overall access to care. And they look at the private market and the Medicare market. And I am just quoting from their report: Results from our 2010 survey indicate that most beneficiaries have reliable access to physician services, with most reporting few or no access problems. Most beneficiaries are able to access, able to schedule timely medical appointments and find new physicians when needed. But some beneficiaries experience problems, particularly when they are looking for a primary care physician. Medicare beneficiaries reported similar or better access than privately insured individuals aged 50 to 64. On a national level, this survey does not find widespread physician access problems, but certain market areas may be experiencing more access problems than others due to factors unrelated to Medicare, or even payment rates, such as relatively rapid population growth.

Then if you go on, it states: The Patient Protection Affordable

Care Act of 2010 contains several provisions to enhance access to primary care, including increasing Medicare payments for primary care services provided by primary care practitioners.

Then if you look at the chart, the table they have, and I just want to read what they ask. This is a survey. This isn't anecdotal: Getting a New Physician. Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, how much of a problem was it in finding a primary care doctor/specialist who would treat you?

Medicare program, the answer being no problem, no problem finding a primary care physician. In 2007, 70 percent said no problem. In 2008, 71 percent said no problem. 2010, 79 percent said no problem.

Let's look at the private insurance market, age 50 to 64, all the things that people said would make it work. No problem has declined from 82 percent say no problem in 2007, to 69 percent saying no problem. Now, 10 percent, yeah. In other words, Medicare beneficiaries, according to this nonpartisan analysis, have no problem.

Specialists -- and I think it is important to get the data out because there is anecdotal -- I hear from seniors in my district the difficulty in access. And it doesn't mean that every single physician takes Medicare, just like not every physician is on the plan a lot of us have; I mean, depending on what you choose. But I can tell you, in 1965 Medicare beneficiaries couldn't find -- people, 65 and up, couldn't find any physician willing to take them.

Access to specialists, people who reported no problem with access

to specialists, 85 percent of Medicare beneficiaries in 2007, no problem; as of 2010, 87 percent reporting no problem with access to specialists. Again, higher than in the private market ages 50 to 64 where 82 percent report no problem with access to specialists.

Mr. Chairman, I would like to submit this for the record. And I do think that this whole conversation requires data. And you know, the notion that all of a sudden -- and Mr. Holtz-Eakin, you say in your testimony, today Medicare coverage no longer guarantees access to care. Well, it doesn't mean that every doctor, I agree, signs up to participate in Medicare. But the overwhelming number of doctors do. And in private plans, there are a whole lot of doctors who don't participate in private plans. And I can assure you that under the House Republican plan, when they are going to be providing a much smaller allotment, and you are going to be leaving it to Federal employees to establish the standard benefit plan but insurance companies to decide what benefits they are going to provide, you are going to have a real access problem.

And I would ask Ms. Feder if she could just comment on that issue.

Ms. Feder. Absolutely. I was listening. I appreciated what you were -- you read my mind or we were on the same wave length because of that MedPac evidence. But you had it first. It was in your mind.

The issue that I have been thinking about is what is it that you are thinking that these private health plans are going to be able to provide people in terms of access if you give such a limited voucher? People who can add on the extra dollars may -- the very well-off seniors

may be able to get a decent plan. But you are not giving them enough money to shop with. So anything that you even think may exist in the current Medicare plan is bound to exist when you have actually given seniors fewer dollars to pay for more expensive plans.

Mr. Van Hollen. Thank you. Thank you, Mr. Chairman.

Chairman Ryan. Now it is Mr. Lankford.

Mr. Lankford. I want to be able to respond real quick to the statement that Ms. Wasserman Schultz made earlier. And just talking about, you know, there is nothing in this IPAB that is going to reduce costs or reduce reimbursements or that can't change the prices on things. And that is just not in the law.

In a meeting about 4 weeks ago that freshman legislators of both parties had with Timothy Geithner to be able to talk about some of the President's plan for dealing with deficit reduction in future days, we walked through section by section of many issues with them. One of them was dealing specifically with health care, because at the time the President had not released a plan for how to reduce costs in Medicare and Medicaid and what the plan was. He had made multiple statements saying we need to bring costs down, and we are going to work on that. So we asked him the specifics of that.

Specifically, Timothy Geithner stated the way they we were going to get savings over the next 10 years in Medicare and in Medicaid is by cutting the reimbursement rate to doctors, hospitals, and drug companies through IPAB. So if this is not in the law, someone needs to inform the Secretary of the Treasury that that is not how we are

going to get these millions and billions of dollars of savings, because the President's spokesman is stepping out there and saying the way that we are going to accomplish this is by cutting reimbursement rates to doctors, hospitals, and drug companies to gain cost savings for Medicare and Medicaid.

So it is very difficult for me to hear one person say that is not in the law, and then the Secretary of the Treasury say that is the way we are going to accomplish that.

I also have difficulty in processing through the power that has been given to IPAB in saying, because there is medical innovation that needs to be done with how we handle the cost savings, we are going to give this power to this independent group and give them the authority to be able to accomplish this. This is a unique situation to say we have a very difficult issue; apparently Congress is having a difficult time cutting back the costs on this, and so we are going to empower this group to basically create law.

Well, here is my question that I would have asked Secretary Sebelius. GAO makes reports about how to be able to save money in HHS. I am interested, if IPAB has the authority to be able to make recommendations that require a supermajority from Congress to change, to giving to GAO the capacity when they do a risk assessment on HHS and cost savings, the authority to be able to make cost savings suggestions about that. And I would like to empower the inspector general of each of these agencies to say when you find fraud, or when someone rises up on the high-risk list, which multiple agencies are

on the risk list for GAO, I would like to just empower them the same way IPAB has empowered them. Give them the power of law and to say whatever recommendation you make about how to reform the Department of Energy, the EPA, the Department of the Treasury, whatever it may be, let's just empower the inspector generals and the GAO, when they make recommendations, that they have that same authority with IPAB. Mr. Holtz-Eakin, do you think that is a good idea?

Mr. Holtz-Eakin. No.

Mr. Lankford. Why?

Mr. Holtz-Eakin. Ultimately, I believe that the Congress has the responsibility to make these policy decisions. And having made them, the executive branch has the responsibility for implementing them. Congress then has to turn around around and do the oversight. That is the standard of practice in the United States. It has by and large been quite successful, and it is the practice I would suggest you adhere to.

Mr. Lankford. Okay.

Ms. Feder, what do you think about that, if we go ahead and empower the inspector general and we empower GAO to go ahead and make recommendations, the same authority that IPAB has?

Ms. Feder. I think it is different. And what I think that the IPAB does is, they are able to do, which is what I think Ms. Wasserman Schultz was getting at, is to look at, to assess what is going on in payment and make recommendations, as Doug said, not so differently from the way MedPac does, but with more authority to --

Mr. Lankford. Not so differently than what GAO does and a lot of other agencies. Very similar. I mean, they look at reports, they go through all these, they make recommendations, they say this would be a great way to save money, hand it to the Congress to make the decision.

Ms. Feder. I did not advocate it. I will go there. I think that we have an issue in terms of health care cost growth that requires this.

Mr. Lankford. Quite frankly, we have an issue with agency growth.

Ms. Feder. Well, I will stay where I am. I think that the Nation's health care cost growth, not Medicare's, but the Nation's health care cost growth is a matter of dire concern. And I think that this is a mechanism which I would argue leaves authority in the Congress. The Congress can reject it with 60 votes in the Senate, or it can come up with alternative mechanisms in order to achieve spending restraints. And I think that that, at this point in time, is helpful.

Mr. Lankford. I would have to say that I don't think that is a good idea to give that authority to GAO either, or to the inspector generals. Neither do I think it is a good idea to give it to IPAB, to be able to say they have some supermajority that they can shut down and create law based on their recommendations.

And with that, I yield back.

Chairman Ryan. Thank you. Mr. Woodall.

Mr. Woodall. Thank you, Mr. Chairman. I appreciate that.

Dr. Feder, I had a couple of questions for you. I appreciate what

you closed your testimony with, that you think IPAB would be a wonderful thing for public and private plans alike. And we get so many shades of gray here it is nice to have some clarity.

Tell me about what Ms. Wasserman Schultz said before she left the room. She said we used to have a copay on programs, and now they are free. She was describing some of the changes in the President's health care plan. As we talk about rising costs and how to get those costs under control, when you used to have programs that had a copay and now those programs are free, what does your experience lead you to believe? Does that lower cost because you are getting more people in the system, or increase cost because you are having more utilization?

Ms. Feder. The question is, which services? And the copays have been eliminated, as they would be also for other people in the Affordable Care Act, and I think some of that has gone into effect as well for preventive services. And it is based on the premise that getting service, getting a checkup, getting service early, actually reduces the possibilities of more costly illness down the road. It is based on -- in some cases it does do that. In some cases it doesn't. But it is based on evidence that is tied to the importance. The best evidence, for example, is prenatal care, not for the Medicare population but for the younger population. Immunizations. So it is preventive service that this focuses on.

Mr. Woodall. Now, I look at the Federal Employee Health Benefit Plan. I happen to have the absolute cheapest plan that is on the menu. It is an Aetna health savings account. I have access to any physician

I want to go. I have access to any service that I want to utilize, and I pay absolutely nothing out of pocket for those. It all comes out of my medical savings account. And yet it is the cheapest program on the menu.

Why is that true? Why is it that when I am in charge of my care, I get the cheapest plan on the menu, but when all of the benefits are pre defined for me, it actually turns into the most expensive plan on the menu.

Ms. Feder. I think one of the issues is who is choosing the high-deductible plans, and so you have to look at selection and whether healthier people who do not expect to use services may be actually in those plans, because you do save on the premiums. And I would hope that you have been in good health. And I would venture to suggest that in all likelihood, so that the population being served is a generally healthier population. So I would have to look at that selection issue before making a comparison.

Mr. Woodall. I am not going to quote you exactly. But as fast as I could write it down as you were responding to a question, you talked about how we get sent out into the marketplace under the Republican health care plan to make decisions without the government to set prices on our behalf.

Ms. Feder. What I said was that we are as individuals negotiating with insurers, rather than having the government, the public program, Medicare, as an insurer. And I think that I would prefer to have Medicare do it for me, based on what I see in the marketplace.

Mr. Woodall. Thinking about your vision of having IPAB control private insurers as well, I did have to go in for a chest CT recently, pulled up a list of providers on-line, shopped around for prices. There was about a threefold disparity between the one that was right next door to me, that happened to be three times more expensive, and the one that was about 4 miles across town that was a third of the cost. I got in the car, I paid the \$4 a gallon to go get the one that was a third of the cost, because it was coming out of my medical savings account.

Why does government price fixing of a price for everybody across the board lead to a better outcome than me seeing those prices and making that decision on my own?

Ms. Feder. Actually, let me move it just a little bit to where the Affordable Care Act is trying to go in terms of, I think, having an improved position over the fee-for-service, because I think that there is a problem with paying fee-for-service and having ever more and ever more expensive care. And I will share with you a conversation recently with a private insurer who would like to partner with Medicare in an alternative approach, a medical home approach, in which it would be physicians who would be rewarded for delivering care more efficiently and it would be they, in conversation and working with their patients, who would be selecting the place that was best and most affordable, or, excuse me, most efficient. That is not an issue here. It is the most efficient. And I think that that is a mechanism.

And as I have said, we continue to sound -- the conversation sounds

as if we are heading down a continuation of health care system as we know it, when in fact the Affordable Care Act is moving us and leading us and working with the private sector to move in a different direction.

Mr. Woodall. Well, that plan that you described sounds strikingly like the PACE program that Bob Dole championed in the late nineties where you combined Medicare and Medicaid together and let folks make those decisions. I thought that was a wonderful program. I hope we will have a chance to get back to exactly that kind of help.

Ms. Feder. I appreciate your drawing on PACE because PACE actually turns to -- serves the most vulnerable dual-eligibles, people on Medicare and Medicaid who need long-term care, and long-term care in particular is a major problem for people today. And I thank you for interest in that program.

Chairman Ryan. Thank you. If you could bring up chart one, please.

This shows a comparison of inpatient hospital services reimbursements. Right now, Medicare is paying about 66 cents on the dollar to providers. In the outyears it goes down to 33 cents on the dollar. That is where we are right now under current law.

Next chart please, chart two.

Doctors. Right now, we are paying about 80 cents on the dollar. Therefore it is a little higher and therefore the access is not so bad. By 2030 it goes down to 40 cents on the dollar.

The SGR, we have played with this hot potato for a long time, and what we learned out of this experience, the 1997 budget agreement, which

is really held up as a hallmark budget agreement -- Republicans working with the Democratic President to get a budget agreement, which, by the way, cut taxes and cut spending -- what we got out of that were price controls on Medicare and payment systems which are producing these results. And the current Affordable Care Act finishes the job in going in that direction.

And what we learned out of that, at least our lesson was price controls don't work because, like we said, from Diocletian to Nixon, when you pay less for something, you get less of it. And so what we learned out of that was nursing homes are going out of business. They are just dropping Medicare. Home health agencies. The entire Medicare provider network was fraying at the edges and they are just not going to take -- they are going out of business and stopping the provision of Medicare services to Medicare.

So we did two laws since 1997, BBRA and VIPA, plowing the money back to keep the Medicare system from imploding on itself, to keep the beneficiary access going. And so it has been said this morning that IPAB is a back-stop, it is a fail-safe. What it is is, it is political cover for politicians not to have to make the decisions to cut reimbursements to providers. It is like the Base Closing Commission. We didn't make the decision, somebody else did. And that, unfortunately, is where this whole thing is headed. Not just in health care, I would remind you, in other areas of law.

And so here is what we know. Ten thousand baby boomers are retiring every single day today. And a lot less people are following

them into the workforce. For those people who had kids in the fifties and sixties, they did a great job. They had a lot of them. But we didn't have as much since then. So we are having about 100 percent increase in the retirement population. But because this is a pay-as-you-go system, current taxpayers pay for current beneficiaries, we only have something like a 17 percent increase in the tax-paying population.

In 2000, 25 percent of Medicare was subsidized with the general fund. We would go out and borrow money in the credit markets to pay for 25 percent of Medicare. Today it is 51 percent. It is going up. And so the problem we have is, not that we don't have the political will to cut costs or reimbursement rates -- we don't -- but more importantly, we know if we just do price controls we will just deny access. The program will fall in on itself.

So the solution for this problem from our perspective is not to delegate all these decisions to unelected bureaucrats, 15, who just arbitrarily make these decisions, and if we don't like them we have got to have a three-fifths, we have to have a supermajority vote to overturn them and then replace those price controls with other price controls within Medicare somewhere else. The whole thing is designed to take accountability away from politicians, meaning people's elected representatives, and give all this power to 15 people to just do this unilaterally.

But at the end of the day, our conclusion is this won't work because if you are paying a doctor or a hospital, you know, 66 to 33

cents on the dollar for the services they are providing Medicare beneficiaries, they are just not going to provide that service. And so I don't know what you call that, other than rationing, by some other word.

And so what we are saying is we have seen lots of evidence throughout history that choice and competition works. And we have seen lots of evidence throughout history that price controls don't. And so why do we believe in choice and competition? Because it doesn't put 15 bureaucrats in charge. It puts the person in charge. They get to decide.

More importantly, having been on the Ways and Means Committee, overseeing Medicare for 12 years, you don't want a handful of politicians, let alone a handful of bureaucrats who aren't even elected, to play thumbs-up or thumbs-down on what providers can and cannot get for providing services. You want the consumer, the patient, to do that.

More to the point, what we want are the providers of medical services to have an incentive to please us as consumers -- to have an incentive to root out waste, fraud and abuse, as they do today, and they root out a heck of a lot more than traditional medical fee-for-service does -- to meet our needs.

And since money is finite, and since we have an infinite funding problem with Medicare, our point is this: People who are already on the program, people who are about to retire, a promise was made to them. It is an unfunded promise. It is a promise that at the lowest estimate,

it is \$31 trillion in the hole, but it is a promise that was made.

Our argument is if we get ahead of this problem now we can keep that promise. If we start turning the curve on our fiscal problems, prevent a debt crisis in this country so interest rates don't spike and the 51 percent financing of Medicare from the general fund, which is borrowed money, doesn't go up, we can keep that promise. And so we think we should do that. And we believe if we do that, by getting rid of IPAB, and therefore its price controls, we can keep this promise to current seniors.

But in order to cash-flow that promise and keep our borrowing down, keep our interest rates down so we can afford that promise which currently is unfunded, you have got to change it for the next generation. And the way we should change it for the next generation is let's recognize that there are people in society with needs greater than others. If you are sick, you have greater needs than a healthy person. If you are poor, you have greater needs than a wealthy person. So let's put our money there; \$7,800 more, to begin with, for a low-income person, and that grows every year. If you are sick, your payments go up.

It is not a voucher. Everybody likes to say "voucher." Premium support and vouchers are two distinctly different things. A voucher is you get a check in the mail and then you go out and buy something with that check. That is not what we are talking about here. Just like prescription drug benefit. Medicare pre screens a list of plans, just like they do for Federal employees, and you choose your plan that

is Medicare-certified and regulated. And then Medicare subsidizes your plan. More if you are poor, more if you are sick, less if you are wealthy. Why? Because wealthy people have more money, so they can afford more out-of-pocket costs.

But more importantly, these providers have to compete against each other for our business. And so if a woman on Medicare doesn't like her plan, she gets to fire that plan and get another one next year. More importantly, that plan knows it. If they don't make her happy, if they don't give her what they say they would at a competitive price, she will fire them and she will go to their competitor.

That is why Ford is better, because of Chevrolet or because of Toyota. And that is the whole concept here. The problem we have got is we think we can do this on the cheap. We think we can just fix this problem if we politicians wash ourselves of the responsibility and let some distant bureaucrat make the decision. I have seen it so many times where a constituent will come and complain about what the government is doing to them, and the elected representative says, I wish I could help you but I can't. It is something the bureaucrats do over the executive branch. That is not what this country was designed to be like. It is not democracy. It is not government by consent of the governed, and it won't work.

And so what we are simply saying is, we don't believe that this works. The other 80 percent of our economy functions on choice, on competition, on price. We want to inject those market fundamentals -- transparency on price, transparency on quality, and

an economic incentive to act on those things to fix this problem. And so we just have a very difference of opinion.

And Mr. Holtz-Eakin, I just simply want to ask you in closing, if we do the SGR, like we always say we will -- and we will, I have no doubt -- we will stop doctors from getting cut 29.4 percent this year, and then stop it again next year, because we are in control of it, elected representatives.

If we do that, what will be the general fund transfer to Medicare in the future? Medicare is already being financed, 51 percent of its budget, by floating bonds and borrowing money. If we stop those cuts -- because right now Congress can, IPAB doesn't run that right now -- what will be the general fund transfer with borrowed money going into the future?

Mr. Holtz-Eakin. Well, I mean we know that just keeping payments level for 10 years is going to cost well over \$300 billion at this point. And you know, you are raising that 51 percent, something that is probably going to be closer to 55, 60 percent. I have to do the math to give you the exact answer. I would be happy to do that.

[The information follows:]

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

Chairman Ryan. So I just want to ask Ms. Feder, Dr. Feder, you say that we ought to have IPAB for all of health care. Do you believe that we can better sort of organize or plan the health care system if we can put IPAB in charge of the rest of the payment systems for the private market as well? From age 1 to age, you know, to the end of life?

Ms. Feder. What concerns me, Mr. Chairman, is that it is an assumption that the private sector, when you do your 30 cents on the dollar or 60 cents on the dollar, that that dollar is somehow immutable as to what health care ought to cost. And what we have seen in MedPac documents is that where the private sector, along with Medicare, is actually working with providers to slow cost growth and are adopting policies to slow cost growth, there hospitals are not losing money on Medicare because they have become more efficient. It is where there is not that kind of behavior in the private sector that essentially the private sector costs grow. They offset whatever is constrained on the Medicare side, and providers continue to operate as they do.

So I am glad, I think you do get me, and what I am saying is that we need to change the incentives for the entire health care system.

Chairman Ryan. I don't think anybody really disagrees with that. So I think the difference here in execution is instead of having one experiment run by the Federal Government, where we are subject to the whims of their decisions by an unelected bureaucracy, why don't we have more than one experiment? Why don't we have a marketplace that is designed to compete for our business? But, more importantly, give

people power. Give people power, especially on Medicare, that they can't be denied care when they choose their plan. Give low-income people a lot more money to cover all their out-of-pocket costs, and not as much to higher-income people.

Ms. Turner, let me ask you the final round of this. Where do you think this is going to head if we stick with the current law? What is the world going to look like in 10 to 20 years if we just basically freeze the law in place as it is today, as it is coming into, what is it going to look like?

Ms. Turner. Mr. McClintock was wondering what people will do. And I think we can look at what happens in Medicare today. People go to emergency rooms to get routine care because they can't find a private physician to see them. And I believe the current MedPac statistics show that the fact that the Congress will continue to do -- has continued to do the SGR fix, has allowed access to continue.

But the important thing is that this legislation assumes that deep cuts down to 33 percent of current private payment go into effect, that absolutely is going to have an impact on patient care and patient access to care. And the choice that the chairman has been talking about is really the way to move to a different system. It is really not can we fix this system.

We know Congress has tried everything it can do, and now instead of trying to fix it, we are going to put more restrictions, more bureaucrats in charge of making decisions about payments. And that can only lead to restrictions on access to care, to physicians dropping

out of the programs, to people, as we see in Medicaid, as we see in Europe, in Kansas, in some provinces, a quarter of citizens can't find a GP, an access physician to see them. They wind up having to go to hospital emergency rooms.

That is what I worry, is that we are going to relegate people to those kinds of access systems that are not the promise they have been given.

Chairman Ryan. Dr. Holtz-Eakin, do you want to jump in?

Mr. Holtz-Eakin. I just simply believe that Grace Marie is too optimistic. That answer presumes that there remains the capacity for the rest of the U.S. budget to transfer to Medicare and Medicaid enormous amounts of resources, and the only fight is over how much of that goes over, and thus how much turns into increased budget costs versus restricted access. That is not going to be true.

We know the projections for the overall budget, and we know that when they hit a certain point, the underlying 80 percent of the economy from which the health care sector is now drawing all of its money is going to collapse. And so we have a problem that is bigger than just a genuine and serious problem with beneficiary access to care. We have a problem that mutates past that to being a fundamental threat to our economy. And so the choices that will be made in the future, if we don't change direction now, will not be the choices we make. It will be the bankers' decisions on how this all gets run. And that is not a future we should tolerate.

Chairman Ryan. Well, thank you very much. I appreciate the

indulgence and appreciate everybody's time. This concludes our hearing.

[Whereupon, at 1:01 p.m., the committee was adjourned.]