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RPTR HUMISTON

EDTR HOFSTAD

A PERMANENT SOLUTION TO THE SGR:

THE TIME IS NOW

WEDNESDAY, JANUARY 21, 2015

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:17 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton, Green, Engel, Capps, Schakowsky, Castor, Matsui, Lujan, Schrader, Kennedy, Cardenas, and Pallone.

Staff Present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Sean Bonyun, Communications Director; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary;

Brad Grantz, Policy Coordinator, O&I; Robert Horne, Professional Staff Member, Health; Tim Pataki, Professional Staff Member; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment & Economy; Macey Sevcik, Press Assistant; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Health Policy Coordinator; Ziky Ababiya, Minority Policy Analyst; Jeff Carroll, Minority Staff Director; Eric Flamm, Minority FDA Detailee; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; and Arielle Woronoff, Minority Health Counsel.

Mr. Pitts. Good morning, ladies and gentlemen.

The subcommittee will come to order.

The chair will recognize himself for an opening statement.

I would like to welcome everyone to the first Health Subcommittee hearing of the 114th Congress and officially welcome our new members on both sides. On our side, we have Larry Bucshon, Susan Brooks, Chris Collins -- I don't see him -- and Billy Long, who is on the committee, is now on the subcommittee, Health Subcommittee. So they will be a great addition.

This subcommittee has made permanent repeal of the flawed Medicare sustainable growth rate formula, or SGR, a top priority for the last 4 years. In 2014, we reached a bipartisan, bicameral agreement on a replacement policy that enjoys widespread support both in Congress and among the stakeholder community.

With the current doc fix expiring in less than 2 months, at the end of March, we are faced with the best opportunity in a decade to permanently dispose of the SGR. We are committed to rising to meet this challenge.

And now, with the policy agreed to, the question we face is how to responsibly pay for SGR reform in a manner that can pass both houses of Congress and be signed by the President. Coming up with approximately $140 billion in offsets will not be easy, but it is a task we must embrace.

Some argue that SGR reform does not need to be paid for. I respectfully disagree.

First, if Members are serious about seizing this historic moment to pass SGR reform, as a purely practical matter, for the bill to pass the House of Representatives and Senate it must include sensible offsets. For example, in recent years, the Senate already tried to pass a full repeal of the SGR under a Democratically controlled Senate. On October 21st, 2009, the Senate considered Senator Stabenow's bill, S. 1776, and that bill failed on a 47-to-53 vote even though there were 60 Democratic votes in the Senate.

Second, the American people expect Congress to live within our means. The American people expect Congress to reduce the debt and prioritize spending. It is our responsible to lead accordingly.

Third, not paying for SGR reform would ignore past precedent from Congress, whether it was controlled by Democrats or Republicans. As the Center for a Responsible Federal Budget has noted, quote, "Lawmakers deficit-financed the first doc fix back in 2003 but since then have offset 120 out of the 123 months of doc fixes with equivalent savings. That is 98 percent," end quote.

So today we are here to take the next step in our process, discussing a range of commonsense Medicare policies which can improve, modernize, and strengthen Medicare. Most of the policies we will be discussing have been endorsed by Members of both political parties, included in the President's Fiscal Commission

recommendations or included in one of the President's budgets submitted to Congress.

As we move forward to get SGR reform across the finish line, we look forward to be discussing these and other options with the minority and the Members in the Senate.

And we are very happy to have with us today some extremely well-respected thought leaders who have demonstrated they are serious about helping save and strengthen Medicare and doing so in a bipartisan manner.

So I welcome all of our witnesses. We look forward to hearing your testimony.

And I yield the remainder of my time to our new vice chair, the gentleman from Kentucky, Mr. Guthrie.

[The prepared statement of Mr. Pitts follows:]

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

Mr. Guthrie. Thank you, Mr. Chairman.

And I appreciate you holding this hearing and the opportunity to discuss the SGR, a critical issue for our Nation's seniors. And since coming to Congress, I have heard repeatedly from Kentuckians that solving the SGR permanently is essential for beneficiaries to have continued access to the care they rely on.

I am proud of the work this committee has done over the past few years to get to this point. We have a bipartisan, bicameral replacement proposal that will repeal the SGR and move forward with a new payment structure that focuses on quality and innovation.

Unfortunately, the issue of how we offset the $140-billion price tag for SGR is still unresolved. We must continue to focus on finding ways to pay for the SGR proposal, and I want to specifically thank our panelists today and tomorrow who have put forward thoughtful proposals.

I am hopeful this hearing will be the beginning of meaningful discussions and produce real bipartisan, commonsense solutions to the real SGR, reduce Medicare costs, and protect the beneficiaries.

And to echo what the chairman said, we have a very distinguished panel, very important thought leaders.

And it is very much appreciated that you guys are here today.

Thank you.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Mr. Guthrie follows:]

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

Mr. Pitts. I am now very pleased to recognize our new ranking member, the gentleman from Texas, Mr. Green.

I look forward to a good session working together.

Five minutes.

Mr. Green. Thank you, Mr. Chairman.

And like you, we have some new members of our subcommittee. Congressman Lujan has been on our committee, full committee, but he is new to our subcommittee. And also new members to the full committee is Congressman Kurt Schrader from Oregon, who is new to the Energy and Commerce Committee and obviously new to the Health Subcommittee, and also Congressman Joe Kennedy from Massachusetts.

Welcome, both of you, to the full committee and also to the Health Subcommittee.

And, Ben Ray, you have been around a while. I am glad you are on Health now. So, appreciate it.

Our other Members new to our Health Subcommittee and the committee: Tony Cardenas, who is not here right now but will be on the committee, and so will Doris Matsui and John Sarbanes, new members on the subcommittee.

Thank you, Mr. Chairman, and thank our witnesses for being here today.

Eliminating the sustainable growth rate, or the SGR, formula under Medicare will represent a major policy development. It is critically important that Congress institute a reasonable and responsible payment policy for physicians and reward value over

volume.

The repeal-and-replace legislation negotiated last Congress made a historic agreement between the House and Senate committees of jurisdiction. Together, a bipartisan bill was introduced to permanently repeal the SGR and replace it with a value-based system that provides stability for physicians and maintains beneficiary access.

Since 2003, Congress has enacted 17 patches to delay cuts to Medicare physician payments derived from the flawed SGR formula. The total cost of these 17 patches has been $169.5 billion. This amount exceeds the current cost of the bipartisan repeal-and-replace legislation developed last Congress. The Congressional Budget Office projects an SGR fix will cost $144 billion over the next 10 years.

Insisting SGR reform to be fully offset is a tough issue and a policy my Republican colleagues frequently abandon when it is politically convenient. Last week, the House passed a bill changing the definition of a full-time employee from 30 hours a week to 40 hours. It added $53 billion to the Federal deficit over 10 years, but it was not paid for. And it passed the House.

Responsible Federal spending is important; however, offsetting the cost of the SGR on the backs of the beneficiaries is unacceptable. Seniors already pay their fair share of Medicare. Half of all beneficiaries live on less than $24,000 a year. On average, health expenses account for 14 percent of

Medicare-household budgets. That is nearly three times as much as non-Medicare households.

Most of the proposals for Medicare savings would increase what is already a substantial burden on beneficiaries and increasing out-of-pocket costs and limiting access to services.

It is important to note that the Medicare program is stronger than ever. The 2014 Medicare Trustees Report estimates that the Medicare Part A trust fund will now be solvent until 2030, 4 years longer than it was estimated in 2013. This is in part because of reforms in the Affordable Care Act.

Projected Federal spending for Medicare and Medicaid has fallen by almost $1 trillion since 2010. When compared to the Congressional Budget Office's August 2010 and August 2014 baselines, Medicare spending this year will be about $1,200 lower per person than expected in 2010.

Controlling costs alone without considering revenue is not a realistic approach to Medicare solvency and putting our Nation's seniors at risk. The flawed SGR formula has plagued our healthcare system for too long, but a fix in SGR that harms Medicare beneficiaries because of an insistence on offsets that reduce benefits and limit access is not an acceptable tradeoff. And I urge our colleagues to work together and enact a long-term, overdue SGR reform for our seniors.

And, with that, Mr. Chairman, I would like to ask unanimous consent to place into the record a letter signed by 17 national

nonprofit agencies, a statement from Stand for Quality, and a letter from the American Federation of American Hospitals. I ask unanimous consent to have that placed into the record.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

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

Mr. Green. And, with that, I will yield the remainder of my time to our colleague Congressman Kennedy.

[The prepared statement of Mr. Green follows:]

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

Mr. Kennedy. Thank you to the ranking member for yielding briefly.

Thank you to the chairman for calling the hearing, and thank you for letting me join you. It is an exciting day for me. So, glad to be here.

Like most of my colleagues, I was hopeful that last year's strong momentum to pass an SGR fix would result in bipartisan legislation that meets the needs of both beneficiaries and workers and providers as well. I am even more hopeful that we can reach an agreement that doesn't pass these costs to fix the system on to America's seniors.

Half of all the Medicare beneficiaries live on less than $23,500 a year, and health expenses accounted for more than 14 percent of Medicare-household budgets in 2012. These numbers tell a startling story about the economic reality most seniors face.

As we take up a renewed push to fix the SGR, let's keep seniors at the forefront of this debate. They have earned their benefits. Now let's make sure we can afford them.

I also want to thank the witnesses for being here today.

Senator, thank you for your service to your country.

Mr. Pitts. The gentleman yields back.

[The prepared statement of Mr. Kennedy follows:]

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

Mr. Pitts. The chair recognizes the chairman of the full committee, the gentleman Mr. Upton, for 5 minutes.

The Chairman. Thank you, Mr. Pitts.

This week's hearing is indeed an important opportunity to discuss bipartisan reforms to strengthen and improve the Medicare program while helping achieve the savings needed to pay for a permanent solution to the flawed SGR.

Last Congress, this committee, along with our colleagues at Ways and Means and Senate Finance, came to an agreement on policy to finally remove the uncertainty that has plagued seniors and their doctors for way too long. Still to be resolved was a path to pay for this important policy change.

The experts here this week will help us explore some bipartisan proposals to both strengthen the Medicare program as a whole while also finally removing the threat of the SGR permanently.

This is an historic opportunity. Securing a permanent solution to the SGR is more than tinkering with how we pay doctors who treat Medicare patients. This can also be Medicare reform.

And while it is important to pay for the policy, I want to caution us about framing our discussions as one of merely budgets or beneficiaries. The truth is Medicare's budget is out of control and the program is on the fast track to insolvency. That threatens the long-term access to care for millions of deserving seniors who depend on the program. That is not right.

So the most pro-beneficiary reform that we can adopt this Congress are ones that will not only remove the threat of SGR but also shore up the Medicare program with sensible reforms that make the programs more sustainable for years, perhaps generations, to come.

Failure to pass a permanent SGR before March would not be due to a lack of policy options but a failure of Congress to work together on offsets with the same bipartisan spirit that we exhibited on the policy itself. This subcommittee has proven that it is indeed capable of working together, and I think that we are ready to do it again. I am absolutely committed to working with my colleagues on this committee and the House and the Senate to finally get it done.

There is a path forward. It involves targeted reforms, which save money without cutting care. It involves a balance of pay-fors, which are bipartisan policies. And it involves a spirit of cooperation with sustained commitment.

Seniors in my State and others and across the country deserve the peace of mind that their trusted doctor will be able to answer their calls for care.

I yield the balance of my time to Dr. Burgess.

[The prepared statement of the chairman follows:]

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

Dr. Burgess. I thank the chairman for yielding.

I thank Chairman Pitts for calling the hearing.

Ranking Member Green, it is good to see you sitting at the top of the dais as well, sir.

It is important that this is the first hearing of this subcommittee in this term of Congress. This committee continues on a bipartisan basis to demonstrate previously unparalleled leadership in our efforts to repeal the sustainable growth rate formula. The countless hours of negotiations that Members and staff have devoted to this issue over the past 2 years have produced the only -- the only -- bipartisan, bicameral, tri-committee agreement, and that occurred on February 6th of last year.

This work -- and I was proud to help the chairmen and the ranking members -- was embraced by organized medicine, beneficiary groups, and payers, producing over 750 letters of support.

I want to thank the chairman for mentioning the votes that were taken in October and November of 2009. That was a particularly trying time for me. The Senate, of course, had the 60 votes, but they could not pass a repeal of the SGR. Then, in what really can only be marked as an episode of legislative futility, after it had failed in the Senate, Speaker Pelosi brought it up on the House side. Really solidifying my allegiance to the patron saints of lost causes, I was the only Republican vote for that bill that was brought forward in the House in

November of 2009. But this is how strongly I feel about this issue.

If you go to a Web site called MedPage Today, the number-one clicked-on article last year was "Get Me Out of Here: Doctors Looking to Get Out of Medicine." And the SGR -- the SGR -- is the proximate cause for their dissatisfaction with the profession that they work so hard for and that they love so much.

So we have the bill, we have a draft, we are ready to go. All it takes is us agreeing to the offsets. It is hard work; I know it is difficult work. But I know this committee, this subcommittee is up to the task.

And I really would ask my colleagues on the other side of the dais, let's work together, let's get this done for the patients of America, for the seniors of America, and the physicians that take care of them.

And I yield back.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Dr. Gingrey follows:]

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

Mr. Pitts. At this time is pleased to recognize the former ranking member of the Health Subcommittee, now the ranking member of the full committee, Mr. Pallone, for 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman.

And I want to thank you for ensuring that the issue of a permanent solution to the SGR is at the forefront of this Congress' agenda. In addition, holding a hearing early in the session allows our new Members an opportunity to review both the policy and congressional background on the SGR.

While I am very interested to hear from our two panels over the next 2 days, I strongly believe -- and I hope the chairman does too -- that after this hearing we should wait no longer to roll up our sleeves and get down to the work of ensuring the bipartisan, bicameral bill agreed to last year is enacted into law before the March 31st deadline.

We all agree on the policy. We all agree that bill, the previous bill, is a good compromise. It also, most notably, has the support of both provider and beneficiary groups.

The question that has plagued us, of course, is the offsets. And I believe that because the SGR is the result of a budget gimmick and we have already spent $169 billion paying to fix the problem, that offsets, especially those within our health programs, are not necessary. However, if we must include offsets, the war savings, which are known as the overseas contingency operations, or OCO, funds, could be used.

I know some on the other side of the aisle do not share my view. What I hope is that we can agree first that SGR shouldn't be paid for off the backs of beneficiaries. Beneficiaries will already pay for their share of the cost of SGR repeal through higher premiums, and half of all beneficiaries live on less than $23,500 per year.

And, second, this is not the time or the place to introduce controversial Medicare structural reforms or changes. These proposals, like raising the eligibility age or raising the deductible or additional means-testing, should not be considered in a vacuum and will become poison pills that will thwart the bipartisan progress that we have made on fixing the SGR problem.

And, finally, if there is consensus that offsets are required here, then revenue should be on the table. It is shortsighted and arbitrary to cut health programs simply because budget rules say so.

So I am hopeful that this is the year we can get the SGR done. If we do, it will be a bipartisan victory for Medicare, for physicians, and beneficiaries alike.

Mr. Chairman, with the time left, I would like to split it, a minute or so to Representative Matsui and then the rest to Representative Schakowsky, if I can.

Mr. Pitts. Without objection.

[The prepared statement of Mr. Pallone follows:]

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

Mr. Pitts. Ms. Matsui?

Ms. Matsui. Thank you very much, Ranking Member Pallone, for yielding me time today.

We need to solve the SGR problem for our Medicare physicians and their patients, but we can't do it by causing new problems for Medicare beneficiaries. In fact, we should be providing more stability to seniors and people with disabilities by not subjecting the programs that they rely on to annual funding threats.

This committee worked very hard last year with our colleagues on Ways and Means and Senate Finance to come up with a bipartisan, bicameral policy solution to the flawed SGR methodology. Now is the time that we should be having serious discussions about how to move this forward. We should not kick the can down the road once again.

We need to move the system forward to reward value rather than volume, and we need to protect, strengthen, and expand Medicare and its programs. To do this, we need to make the so-called SGR extenders permanent.

The QI program provides premium assistance, and Aging/Disability Resource Centers provide no-wrong-door resources to the lowest-income beneficiaries. As a co-chair of the Seniors Task Force, I am acutely aware that more than half of Medicare beneficiaries live on incomes of $23,500 or less and cannot afford to pay more for their health care.

We owe it to our doctors and their patients to provide this much-needed stability in the Medicare program.

I yield back.

[The prepared statement of Ms. Matsui follows:]

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Mr. Pallone. I yield to Ms. Schakowsky.

Ms. Schakowsky. Thank you.

I am also the co-chair of the Seniors Task Force of the Democratic Caucus, and I am concerned because Medicare beneficiaries currently find themselves in an all-too-familiar situation, worrying that they could lose their doctors if Congress doesn't reach an agreement on the doc fix.

And we do have an opportunity to end these worries forever. The Democrats, as Dr. Burgess, when we were in charge, pointed out, actually did that, a permanent repeal of the SGR. Passing the bipartisan, bicameral proposal would repeal the SGR formula and continue Medicare's transformation into a program that pays for quality, not volume.

In passing the legislation, though, we should follow the precedent set by Republicans, who consistently pass healthcare legislation without offsets. Just earlier this month, the Republicans passed a bill to redefine "full-time" under Obamacare that cost $53 billion without offsets.

If we must include offsets, then we must not cut benefits or ask beneficiaries to pay more. Let me just say that doing so would exchange beneficiaries' worries that their doctors will leave Medicare for worries that they can no longer afford to see their doctor under Medicare.

I yield back.

Mr. Pitts. The chair thanks the gentlelady.

[The prepared statement of Ms. Schakowsky follows:]

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Mr. Pitts. That concludes the opening statements of the Members. As always, any written opening statements of Members will be made a part of the record.

[The information follows:]

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

Mr. Pitts. We have two panels, one today, one tomorrow, on this issue.

And before I introduce the panelists, I have a UC request to enter into the record comments of the American College of Clinical Pharmacy. Without objection, we will put that in the record.

So ordered.

[The information follows:]

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

Mr. Pitts. On our panel today we have three witnesses: Joe Lieberman, highly respected former U.S. Senator -- welcome, Joe -- Dr. Alice Rivlin, co-chair of the Delivery System Reform Initiative, Bipartisan Policy Center, and director of the Engelberg Center for Health Care Reform at the Brookings Institution -- I might add, former OMB Director under President Clinton and Vice Chair of the Federal Reserve -- and, finally, Dr. Marilyn Moon, institute fellow at the American Institutes for Research.

Welcome. Thank you for coming. You will each be given 5 minutes to summarize your testimony. Your written testimony will be placed into the record.

Senator Lieberman, we will start with you. You are recognized for 5 minutes for your summary.

**STATEMENTS OF JOSEPH I. LIEBERMAN, FORMER UNITED STATES SENATOR; ALICE RIVLIN, PH.D., CO-CHAIR, DELIVERY SYSTEM REFORM INITIATIVE, BIPARTISAN POLICY CENTER, AND DIRECTOR, ENGELBERG CENTER FOR HEALTH CARE REFORM, BROOKINGS INSTITUTION; AND MARILYN MOON, PH.D., INSTITUTE FELLOW, AMERICAN INSTITUTES FOR RESEARCH**

**STATEMENT OF JOSEPH I. LIEBERMAN**

Mr. Lieberman. Thanks, Chairman Pitts and Ranking Member Green, members of the committee. It is an honor to be asked to testify before you.

I must say that, a day ago, I got a call in my office from a reporter for a trade publication, and the essential question was, to my executive assistant, why is Senator Lieberman testifying about the SGR problem?

So the answer is that there is a staff member of the full committee, Josh Trent, who used to work for Senator Tom Coburn. And in 2011 Dr. Coburn and I spent a lot of time working together to try to come up with a bipartisan program to save Medicare and to reduce the national debt, and, after a lot of work, we did. And I hope that I can bring some of that experience to bear on what you are facing now.

Let me try to put it in this quick context of this morning's news. The President said last night in the State of the Union

that the shadow of crisis has passed. And I would say, generally speaking, insofar as the deep recession we were in, the economic crisis, the shadow has passed. But there are other very, very deep, dark shadows over our future that have not passed, one of which is, obviously, our continuing-to-grow national debt.

When Senator Coburn and I introduced our Medicare reform plan in 2011, the national debt was just at about a little over $14 trillion. It is 3 years later; we are now over $18 trillion. And this is really unsustainable. It is sustainable only at the risk of putting a terrible burden of taxation on our children and grandchildren or forcing really unacceptable cuts in spending in Federal programs.

The other crisis that has not passed relates to Medicare, which also is a big cause of the growing national debt. And the trustees of Medicare continue to say, just to make it as specific as I can, that Part A, the hospital insurance program, could be insolvent -- which is to say, unable to pay the benefits due to seniors -- as early as 2021 and maybe, under the best of circumstances, as late at 2030. So there is a real problem.

The second thing I want to say is thank you. I mean, beginning in this subcommittee, working with colleagues on other subcommittees in the House and Senate and both parties, you have done something that has been really generally unheralded in a time when Congress has been so gridlocked and unproductive: You have come up with a -- not a fix, but a solution, a replacement, a

reform of the sustainable growth rate formula for physician reimbursement, which hasn't worked. And now the question is, how do you pay for it?

Let me just say in passing, as others who have spoken have, as a Member of the Senate, certainly the public following this, certainly doctors, the SGR was a perpetual recurring crisis, a process crisis. People would use the need to fix it to attach all sorts of conditions to it and the rest.

But the really positive -- there are two positive notes out of that suffering that we all went through. One is, as you have said, that in almost all the cases, 98 percent, the cost of the fix was offset. The second, to me, encouraging reality was that, generally speaking -- well, let me put it this way: that the most significant Medicare reforms that have passed in the last decade were passed to finance fixes for SGR.

So I would say first that I hope that you offset the cost of the solution, the repeal, the reform that you have come up with, because otherwise you are going to increase the national debt. That shadow is over our future.

The second thing is to say that I hope you build on this hidden story of offsetting your repeal and reform of SGR, replacing it, as predecessor Congresses have, by using it as an opportunity to reform some elements of Medicare.

I offer the -- and, obviously, I am happy to answer questions in the next section of the hearing, but I offer the work that Dr.

Coburn and I did as an example. You don't fix the Medicare problem by making everybody happy, but the main thing you can do is to sustain this incredibly important, humane program for the long term.

Dr. Coburn and I negotiated back and forth, and, you know, we did some things that are not popular with everybody. We replaced Medicare's current complicated cost-sharing requirements with a unified annual deductible of $550. But we also created an out-of-pocket maximum of $7,500 so every Medicare recipient would have a cap on annual medical costs to protect them from financial hardship or bankruptcy.

The Fiscal Commission, the President's commission, estimated that that kind of restructuring, along with the Medigap reform that we included, would save $130 billion over 10 years. The total savings estimated by the Centers for Medicare and Medicaid and the President's Fiscal Commission and CBO were somewhere in the $500 billion to $600 billion range over the next decade. And, startlingly, because this is big numbers, over the long term, our proposal would have reduced the unfunded liabilities of Medicare by $10 trillion because it just continues to grow.

We did reform Medigap to increase consumer utilization in a way that makes the system work better. We did recommend raising the eligibility age. We did it, incidentally, in what I thought was a very genuine compromise by Dr. Coburn, who opposed the Affordable Care Act, by referring to the Affordable Care Act and

saying, at every point that we raise by 2 months the age of eligibility for Medicare, the eligibility for access under the Affordable Care Act also goes up 2 months. So you are giving people essentially a floor or an alternative to what they have now.

The bottom line here is that this must be done and it can be done. And if you and your colleagues in both parties, both houses can get together with that same spirit as -- and Dr. Coburn and I always used to say, when people from different interest groups would come, as they have and will to you, and say, "You can't do this," we would always say to ourselves, privately of course, Tom, Joe, we have to think of our grandchildren. In other words, is Medicare going to be around for our grandchildren? And is the country going to be cutting back the debt so that they are not paying unreasonable parts of their income in Federal taxes or losing some of the basic benefits that government gives? Because our successors in Congress will have no choice but to cut Federal spending in discretionary programs to sustain Medicare.

Bottom line, you have heard before, is that the only way to save Medicare is to change it, to reform it. And I think this is a committee where that can begin, and, ironically, the SGR repeal can be the occasion for doing that. I think you have the opportunity to confound the skeptics who don't believe this Congress can do that.

Neither Democrats nor Republicans nor the administration will

get all of what anybody wants in a final bill, if you get to a final bill, but you will get something much more important, which is a solution to a big problem, a real problem. And that, I think, is what the American people want of this Congress more than anything else.

Thank you very much.

[The prepared statement of Mr. Lieberman follows:]

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

Mr. Pitts. The chair thanks the gentleman and now recognizes Dr. Rivlin, 5 minutes, for summary of her testimony.

**STATEMENT OF ALICE RIVLIN, PH.D.**

Ms. Rivlin. Thank you, Mr. Chairman.

I, too, am delighted that this committee is holding this hearing. I think you have a historic opportunity to do two things at once: You can replace the Medicare sustainable growth rate and halt this unfortunate budgetary practice of kicking it down the road every year, and at the same time you can begin phasing in new payment incentives that will nudge Medicare and, indeed, I believe, the whole health system toward high-quality, more cost-effective delivery of care.

I would like to make four brief points.

First, the point you have made yourself and others have made, the SGR should be fixed permanently. This formula, with its pending 20 percent or thereabouts cut in Medicare physician fee schedule payments, just creates unnecessary uncertainty for doctors and their patients. Keeping the formula in the law but postponing its impact every year just makes our legislative process look ridiculous.

Second, replacing the SGR can advance payment reform. It can move the healthcare delivery system away from fee-for-service, which is still very prevalent in Medicare, which rewards volume

rather than value, and move it toward higher quality and less waste. And that is good for everybody, especially beneficiaries of Medicare.

Now, the tri-committee bill that you have spoken of, Dr. Burgess' authored bill, is a very promising approach and does just that. It proposes that future Medicare payment rate updates for physician fee schedule providers be contingent on participation in alternative payment mechanisms beginning in 2023.

This bill is a good foundation, but we and many others think it could be strengthened. My colleagues at the Bipartisan Policy Center are releasing two papers today, which I believe you all have, which recommend accelerating the introduction of higher payments for providers that participate in alternative payment mechanisms from 2023 to 2018 -- you don't need to wait that long -- and applying the incentives to all Medicare providers.

Other recommendations involve other alternative payment mechanisms and, particularly, strengthening accountable care organizations and relating the updates to the amount of risk that they are willing to take on.

These changes could alleviate many of the challenges that providers are struggling with today as they work to implement new models of care.

Now, payment reform is still a work in progress, with many details to be developed. Nevertheless, Congress can develop, at this point, a roadmap that will give providers more certainty that

it is worth investing in the infrastructure necessary to develop alternative payment mechanisms and that the future of healthcare delivery is rooted in shifting to new models of care. These types of reform, I believe, have the most potential to deliver on the promise of improved healthcare delivery that should be at the heart of every SGR fix.

Bipartisan Policy Center is not alone in proposing the various ways of strengthening the bipartisan bill. My colleagues at the Brookings Institution have a set. We strongly endorse the thrust of the bill but urge beefing it up in many dimensions. And we are very happy to supply more information on that subject.

Third, I believe that the SGR reform must not add to future deficits. Cost growth in health care has slowed in recent years, which makes projected health spending appear less daunting than it did in the past. Nevertheless, Medicare spending under the new payment model would be higher, about $144 billion higher over 10 years and more if you include Medicare extenders, than under the present SGR formula. That must be offset. The Congress should not set a precedent of not paying -- for anything, but especially not for a reform like SGR.

But paying for the SGR is also an opportunity to find offsets that are also good health policy. There are a whole bunch of lists of such offsets, and I don't have time to go into them here orally, but I have referenced them in my testimony. And I think there are a sufficient number of quite plausible offsets, that the

Congress should not have trouble finding a good set.

That being said, if you have too much difficulty finding offsets, which will clearly be a heavy lift, we do have a suggestion for a semipermanent fix, working with 5 years instead of 10, which might be a helpful way out of that dilemma.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Rivlin follows:]

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

Mr. Pitts. The chair thanks the gentlelady and now recognizes Dr. Moon, 5 minutes, for her summary.

**STATEMENT OF MARILYN MOON, PH.D.**

Ms. Moon. Thank you, Mr. Chairman.

I am very pleased to be here today to testify. This is an area that I feel very strongly about. All of my research for many years, from initially working with Dr. Rivlin at CBO until today, has focused a lot, most of it, on beneficiary issues, protecting beneficiaries in the Medicare program. And that is where I am going to focus my testimony today.

Eliminating the sustainable growth rate under Medicare would constitute a major policy improvement. And I believe that the instability in payment toward physicians and the contribution that that has made toward the many physicians opting out of the program is a serious problem for beneficiaries and qualifies, itself, as a beneficiary issue as well as an important payment issue for physicians.

But I am concerned about the whole issue of offsets, and that is where I am going to spend most of my time today. There is a sense that there needs to be an offset to pay for this policy change, but I would point out that there is nothing about Medicare's stability that requires that Part B changes be covered by benefit cuts elsewhere. And that, I think, is a very important

concept.

Nonetheless, many of the SGR reform proposals are paired with changes in Medicare at the expense of beneficiaries. If offsets are deemed essential, a reasonable alternative would be to look for policies across the Federal Government that are similarly unwise for which repeal could generate savings and, in many cases, represent the same kind of poor policy that has been recognized over time but not dealt with.

Part of the justification for focusing on Medicare, however, stems from the notion that the program is too large or out of control. But I would point out that Medicare's per-capita growth rates have been less than the rates of growth in the private insurance world for more than 40 years. Medicare has simply done a better job than the private healthcare sector in controlling costs over time.

And another source of growth in Medicare that causes people sometimes to be concerned about the program is the increase in the number of beneficiaries, to this point largely caused by an increase in life expectancy -- again, a success story for Medicare, not something for which Medicare should be condemned.

Finally, the rate of growth in spending on Medicare has declined in recent years. Efforts to introduce new ways to control costs seem to be working. And, indeed, building the SGR change on top of some of those promising reforms, as is part of your legislation that has been considered, is a good idea.

But most of the major reform options being discussed for reducing Medicare spending focus on increasing the share that beneficiaries pay or reducing the number of people eligible. Since people must still get care somewhere, such options are essentially ways of asking beneficiaries to pay more.

Medicare is in no way, however, an overly generous program. Medicare pays only about 70 percent of the costs of just the services it covers, forgetting the other things like vision and dental and other things that Medicare does not cover. Beneficiaries or their families or former employers are responsible for the remainder.

And just as costs to the Federal Government have risen over time, so have the costs to beneficiaries. Beneficiaries' incomes have certainly not kept up with the increased costs in healthcare spending that they must themselves undertake over time.

And the problem is particularly severe for those with modest incomes whose resources keep them above eligibility for Medicaid or special low-income protections but low enough to make it difficult to afford care.

One of the most urgent areas of need is for better low- and moderate-income protections for Medicare beneficiaries, not increasing their burdens. Yet some of the proposals that even seem to be more neutral or across-the-board can have unintended consequences that harm beneficiaries, particularly these more vulnerable ones.

For example, raising the age of eligibility is something that often sounds good, usually to people like me who like to continue working well past the age of eligibility. But for lower-income individuals who have poor skills and poor health, that simply is a major cut in benefits, and it is a major problem for those beneficiaries.

Similarly, raising the premiums to beneficiaries over time would cast an enormous burden on, for example, a woman who is earning just above the paltry level that Medicare provides special benefits for of $18,000 a year, raising her out-of-pocket costs from about 15 percent of her income to 17 percent of her income -- certainly not moving in the right direction in terms of the changes.

So I believe that it is important to recognize that any fix to the SGR that raises Medicare spending will also result in higher costs to beneficiaries when the payments to physicians rise. Beneficiaries will pay more by any fix that you do to the SGR because we are going to increase payments to physicians.

The sustainable growth rate is poor public policy and ought to be fixed, but beneficiaries, I believe, should not be penalized for the poor policymaking that occurred so many years ago.

Thank you.

Mr. Pitts. The chair thanks the gentlelady.

[The prepared statement of Ms. Moon follows:]

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Mr. Pitts. That concludes the opening statements of our witnesses. I will begin the questioning and recognize myself, 5 minutes, for that purpose.

Senator Lieberman, you were eloquent in your testimony about the need to pay for the SGR, yet I am concerned that some voices continue to suggest that it need not be offset.

As a practical matter, House leadership has said that a bill must be offset to be put on the floor for a vote. So I fear that Members or organizations who continue to suggest moving SGR without offsets actually are maybe at best not serious or at worst could doom SGR reform to certain defeat.

In your opinion as a former legislator, do you believe that SGR reform can pass this Chamber without offsets?

Mr. Lieberman. Obviously, in the end -- thanks, Mr. Chairman -- you all will notice and determine it more than I, but my sense, based on the results of the election last November and the stated opinions of those in the majority here and some in the minority, that this extraordinary achievement that began here in the subcommittee, which is to come to a bipartisan agreement on replacing the failed SGR formula, will not make it into reality unless there is an offset.

And, again, there is nothing particularly, based on history here, radical about this. As you said, I believe, Mr. Green, maybe both of you, in 98 percent of the time the doc fixes have been offset for exactly the same reasons that your question

raises.

Mr. Pitts. What would your advice be for organizations considering making a push for an unpaid-for SGR bill in this Congress?

Mr. Lieberman. Well, my advice -- gratuitous, but you have asked me -- is to think of what your goals are. And if you are an organization representing physicians, for instance, and you push for this SGR replacement reform with no offset, the danger is -- and it is a high risk -- that nothing is going to happen and physicians are going to suffer and, as has been said earlier, people are going to leave the medical profession, patients will suffer. If you are representing beneficiaries, obviously the same is true.

So we have to give a little bit here to preserve the essential system, which is a great system. We are about to come to the 50th, if I am not mistaken, anniversary of Medicare, and it would be a tragedy in the midst of this year to have a failure of, I would say, will to find the money to fund this bipartisan agreement you have made.

Incidentally, you can pick and choose from -- you don't have to look to the Coburn-Lieberman proposal -- although, frankly, we did this, too. We took a lot from the President's Fiscal Commission. And the President himself has recommended some changes in the last couple of budgets that would fund $50 billion. That is the part where he increases the premiums on wealthier

beneficiaries.

Mr. Pitts. Thank you.

Dr. Rivlin, there has been a lot of discussion in recent years about the slowdown in the annual growth rate of Medicare spending. You have probably been following the literature and CBO's analysis pretty closely, but my question is pretty simple.

In your opinion, is the slowdown in Medicare spending a reason not to offset SGR reform? And based on your historical perspective, do you think it is likely to rebound in coming years closer to historical averages?

Ms. Rivlin. I don't think we should use the slowdown as an excuse not to pay for the SGR reform.

Whether this slowdown will continue, I think, depends in part on whether we make bolder moves to make the health system more efficient and more cost-effective. And the movement toward alternative payments, alternative payment mechanisms of various sorts -- accountable care, medical homes, bundled payments -- is an effort to do exactly that.

It seems to be working, and it may be part of the reason why the slowdown has occurred, but we can't be sure. And we do know there are going to be a lot more seniors in the future who are eligible for Medicare. And there are a lot more things that docs can do for us -- really interesting and exciting things coming on line, and we are all going to want it.

So the upward pressure on healthcare spending generally and

Medicare in particular is going to continue. And that is the reason I think that we should combine fixing the SGR with strong incentives to use alternative payment mechanisms.

Mr. Pitts. Thank you.

My time has expired. The chair recognizes the ranking member, Mr. Green, 5 minutes, for questions.

Mr. Green. Thank you, Mr. Chairman.

Dr. Moon, some have suggested that the SGR and other reforms proposed should be paid for by shifting additional out-of-pocket costs on to Medicare beneficiaries. However, seniors already bear a significant out-of-pocket cost in Medicare now, and most are living on very modest incomes. For example, half of all Medicare beneficiaries have incomes below $23,500.

A Kaiser Family Foundation study found that an average Medicare household spent almost three times more out of pocket on health care as a percentage of income than the non-Medicare households, 14 percent versus 5 percent.

To me, this a clear illustration that we should not be shifting costs to seniors. Instead, we should be working to strengthen and expand the programs that provide an assistance to the moderate-income seniors.

Can you discuss the cost burden beneficiaries already bear on their relatively low income?

Ms. Moon. Thank you, Mr. Green.

Yes, I agree with you that the burdens are substantial. And

particularly for those modest-income individuals that I mentioned, whose incomes are between 150 percent and, say, 250 or 300 percent of poverty in the United States, receive no protection of any sort beyond the basic Medicare program. They are the ones that are particularly vulnerable and for whom even fairly simple and small changes in cost-sharing can have devastating impacts, because they could cause people to not go and get care, which then ends up costing the system more, ultimately, when they become sicker.

I believe that the aspect that we need to think about in terms of this is that Medicare is not a really generous program. It is a less generous program than most of us who have employer-provided insurance or the standard programs that are offered through the ACA have, for example. So when you begin to raise premiums, raise cost-sharing, you are effectively cutting that back even further and making it a less and less generous program over time.

Mr. Green. Well, and I think most of us don't actually object to paying for it, it is just how you do it. Although I have to admit, last week we passed a bill on the floor that cost $54 billion that wasn't paid for that affected the Affordable Care Act. So, you know, if it is good for the goose, it is good for the gander -- but paying for it out of Medicare and making seniors come up with more cost-sharing.

My next question: Aren't Medicare premiums already income-related? More specifically, can you talk about the

existing income-related premiums and what income levels it affects and how these income levels compare to what is considered upper or higher income in other Federal policy, such as tax policy?

Ms. Moon. Yes. Medicare does have an income-related premium for both Part B and Part D now, and it starts at a level of $85,000 a year. So I rankle when I hear people talk about asking wealthy Medicare beneficiaries to pay higher premiums because, as a society, we like to talk about "middle income" stretching up to $250,000 a year of income but we are willing to talk about "wealthy" seniors at $85,000 a year.

The reason for that is it is very difficult to get high levels of revenues from income-related premiums because there simply aren't enough seniors with such high incomes or persons with disabilities with such high incomes that make it easy to get more money.

So when you begin to talk about further raising income-related premiums, you either have to make even lower-income individuals subject to such premiums or you have to raise those premiums to such a level that no longer is Medicare a good deal for high-income individuals. And that concerns me, as well.

Mr. Green. Okay.

Dr. Moon, we have heard a great deal over the past few years about entitlement reforms. And these entitlement reforms, particularly in Social Security, are the safety net for our society -- Medicaid and Medicare for the seniors and most

vulnerable in our society -- without considering the fiscal impact of tax entitlements, tax deductions, exclusions, credits, and other tax preferences which disproportionately benefit well-to-do Americans. And I think the President talked about that last night.

Can you talk about entitlements, both those providing essential services to seniors and low-income Americans and those providing tax breaks to more affluent Americans, and the relative role of each of these in the context of protecting the most vulnerable in our society and at the same time addressing our long-term debt?

Ms. Moon. A small question.

Mr. Green. In 15 seconds, by the way.

Ms. Moon. Fifteen seconds.

In addition to Medicare and Medicaid, Social Security is also considered an entitlement program. These programs all help support older people when they have retired. They enjoy enormous support. And they are also important in reducing some of the inequality that occurs as people go through their lifecycles and have bad things happen to them. Medicare and Social Security provide that underpinning of support.

I believe they are really important programs. And if we are going to talk about changing programs like that, we ought to talk about revenue sources from other places if we are going to talk about making changes or looking for offsets.

Mr. Green. Thank you, Mr. Chairman, for your patience.

Mr. Pitts. The chair thanks the gentleman and now recognizes the vice chair of the subcommittee, Mr. Guthrie, 5 minutes, for questions.

Mr. Guthrie. Thank you, Mr. Chairman.

And, Dr. Rivlin, I know you have been involved in a lot of different groups and think tanks in working on this issue. And a lot of times in Congress, we keep hearing, we need a lot more information, we need more information, we need more studies. I think Senator Lieberman said we just need some good courage and cooperation.

And so my question is, do you believe the information is there for us to move forward, or do we need another study, or is it time for bipartisan negotiations to begin and move forward?

Ms. Rivlin. I am a studier, so I don't want to say you don't need another study, but I think you have enough information to move ahead now and, indeed, that you should.

And, in my testimony, I endorse the idea of actually accelerating the impact of the incentives to use alternative payment mechanisms that are built into the tri-committee bill. I think we know enough now to do that and to start them in, say, 2018 rather than 2023 and phase in over several years a movement to incent the medical profession to be in new kinds of organizations that take risk.

That is not going to be easy. We will learn along the way.

But I think you can start now.

Mr. Guthrie. The trick is it is -- the way you can measure, it is easier when somebody walks into an office, to know they walk in and pay for volume. It is hard to figure out how you pay for value, because it is hard -- how do you determine in value. That is what is going to be interesting over the next few years to develop those models. So --

Ms. Rivlin. Right.

Mr. Guthrie. -- there will be more studies with that for sure, so we will keep you studying.

Just another -- I know alternative payment models in the SGR. Is there specific things within Medicare currently today you think should be reformed in the current offsets to pay for it? Some suggestions in the current Medicare program?

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[11:15 a.m.]

Ms. Rivlin. Yes, I think I do favor more means-testing of the premium. I think you can do that without hurting low-income people. I also think that the restructuring of the benefit package and the deductibles so you put together Parts A and B with a reasonable deductible, and then, in order to protect lower-income people but also not to discourage them -- anybody -- from going to the doctor, you could have it not apply to physicians visits.

And there are other things that you could do. Accelerating the movement, the incentives for moving to stronger accountable care organizations, for instance, would produce savings, we think, over time.

I am not in favor, unlike Senator Lieberman, of raising the age, partly because it just doesn't save very much money because if you are going to do it, you do have to put those people into some other plan like the Affordable Care Act.

Mr. Guthrie. Thank you very much.

And, Senator Lieberman, you had an op-ed in The Hill, and you said earlier today about a final bill, nobody is going to get everything that they want -- I think that is what you said -- but we can work together so we can tackle big problems. And in the

President's fiscal year 2015 budget, he did include a proposal to charge wealthier seniors on Medicare more for Part B and Part D premiums. And it would save $50 billion -- I think is what was in his budget -- and roughly a third of the cost of the entire SGR bill. Do you think there could be bipartisan consensus for the President's proposal in 2015, for the 2015 budget?

Mr. Lieberman. Well, that certainly should be the beginning of it. Bipartisanship always comes as a result of negotiation and compromise and understanding that you are putting a larger interest, which is a national interest, ahead of a more focused interest so you couldn't just sort of pass that one alone. But that takes care of -- the President's proposal takes care of more than a third of the cost of the SGR replacement reform. And I think you would have to come up with some others that would appeal to people on both sides that could get you to the numbers you need to get it passed. But, no, I think that is a very strong beginning.

Mr. Guthrie. Thank you, Senator.

I just have 17 seconds. I just want to say remember if we do nothing with Medicare -- nothing -- Part A, by 2030, the most optimistic assessment -- and I was born in 1964. That is when every baby boomer will be retired. And if you look at other parts of the budget, about that time, that is when Medicare, Social Security, and Medicaid, and the national debt will be 100 percent of federal revenues. And even if you took the President's

proposal in his campaign and went to the fiscal cliff and added, that is only another $40 billion. So unless you are going to go deeper into taxes and tax more people or you are going to reform these programs, they won't exist after 2030 unless we step forward.

Mr. Lieberman. I agree. I agree with Dr. Rivlin. The facts are there, and the question is what you and we all as a country are going to do about them.

Mr. Guthrie. I yield back.

Mr. Pitts. The chair thanks the gentleman.

The chair recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes of questioning.

Ms. Schakowsky. Thank you, Mr. Chairman.

I want to say that we do have a serious crisis in this country when it comes to budget. And, for me, it is the budget of the senior citizens. And right now we have a retirement crisis. People cannot afford to retire in the United States of America. And I say this at a time that our country has never been richer. This is the richest country on the face of the earth, and per capita GDP has never been higher, but as we all know, that is so unequally distributed that ordinary Americans have not seen an increase in wages for the last three decades, and all of the growth has really gone to the top 1 percent. And now we have a situation where I think we all agree that the SGR has got to go. And, as I said, when the Democrats were in the majority, we did

exactly that.

But this idea that we have to ask senior citizens, who are absolutely struggling right now, on this 50th anniversary of Medicare -- one of the most successful programs we have ever seen, and undoubtedly this pay-for that we are talking about would put additional burdens on seniors: $85,000, as Dr. Moon pointed out, is now a rich senior. Some proposals have talked about lowering the income to $45,000, making people -- seniors who make $45,000 considered rich enough to pay higher premiums.

I say shame on us as a country that we can't afford to provide health care to our seniors and persons with disabilities. There are plenty of places to look. We just passed -- what did we call it -- the Tax Increase Prevention Act; extenders, $45 billion unpaid for. As I said in my opening remarks, just earlier this month, the Republicans passed a bill to redefine "full time," and that cost $53 billion, unpaid for.

But now we are saying in order for doctors to get what they deserve and continue to serve seniors, we are going to ask senior citizens to pay more. I find that repugnant -- I am sorry, and my hair is on fire -- to say that we should go to the elderly and the disabled in our country. I agree that we have debt, but you know, projected Federal spending for Medicare and Medicaid have fallen by almost a billion dollars since 2010. If we compare the CBO's August 2010 and the August 2004 base lines, Medicare spending in 2015 will be about $1,200 lower per person than expected in 2010.

So we are adding incredible savings because of the reforms in the Affordable Care Act, et cetera, to lower the cost of Medicare. And now we are going to turn around and say the seniors in this country are just having to spend more in order to save future generations from debt. I say we have plenty of money, and if we don't start talking about reasonable revenue, as the President did last night in his State of the Union, then, again, I say shame on us. And I hope the senior citizens and the people with disabilities are paying attention to this important debate.

I wanted to ask Dr. Moon, one of the things we expect to see in the budget that is proposed by the Republicans is, once again, this idea of a voucher program for Medicare. I wonder if you would comment on that and the kind of effect that that would have on Medicare beneficiaries.

Ms. Moon. My concern about a voucher program is that if we turn over to the private sector the responsibility for meeting the same kind of challenges that now have to face the traditional Medicare program, we won't necessarily have solved anything. The only way that you can, quote-unquote, solve the problem and make the budget burden for the Federal Government lower is if you insist that you are going to pay in terms of those vouchers less and less over time as compared to what Medicare would otherwise cost.

Then the question is whether or not private entities will do a better job at holding down the costs than Medicare does. I see

no evidence of that over the last 40 years. And if that is the case, it will simply be then the shifting of costs on beneficiaries so that instead of premiums going up at the slow rate they have been going up in the last few years, they would have to go up faster and faster, unless we really find a way of either magically empowering the private sector to do a better job than it ever has, or we find a way to assume that simply handing it over to the private sector causes people to use fewer services and fewer numbers of people to age into the program. I just don't see it as a solution per se. It is only a solution in a budgetary context if what you do is pay less.

Ms. Schakowsky. You know, I referred to in my -- well, we can call it a rant -- the Affordable Care Act made some significant changes that actually has reduced the cost of Medicare. I wonder if you could talk a little bit about that and what we might expect going forward that will actually lower those costs even more.

Ms. Moon. I think we have not as yet seen the full impact of the reforms that the Affordable Care Act was hoping to put into place. I think we have seen some reductions in spending on Medicare that are attributable to that in part because of anticipating what the impact will be. Because as yet we are still experimenting.

We are still trying to figure out what these things will do, how well they will work, et cetera, but they are very promising at

this point because, as Dr. Rivlin pointed out, they are really trying to emphasize quality and value rather than volume. That means coordination of care, which is a really essential part of improving health care in the United States of America. As a very recent primary caregiver for a very sick Medicare beneficiary, I can tell you coordination of care is very poor in the Medicare program now. A lot of efficiencies can be found if we make improvements in that area. That is what medical homes and ACOs have at their heart of what they are trying to do. We need to push for that, and I think it will pay off over the long run.

Ms. Schakowsky. Thank you. I yield back.

Mr. Guthrie. [Presiding.] Thank you. The lady yields.

Dr. Murphy, from Pennsylvania, is recognized.

Mr. Murphy. Thank you.

Great to have you all here. This is very insightful.

First of all, I want to say with regard to some of the issues of persons paying more their first dollar as a way of trying to save money, I recall the Gallup poll that was done, I think, last November or December that said 38 percent of middle class people with a household income between $30,000 and $75,000 have delayed medical care because of costs.

So I ask this, Dr. Rivlin, if people delay care, does it lead to an increase in costs?

Ms. Rivlin. Yes, and that is one of the reasons that I think you have to be very careful in how you do the cost sharing, and

one of the proposals that we have looked at is to not have the deductible apply, as I said earlier, to physicians visits. I think that is a good idea. That means you aren't discouraging people, especially low-income people, from seeking physician care.

Mr. Murphy. I have to keep moving. You support the Alternative Payment Model. I think that is an important point to acknowledge. I read here in the report from the Center for Healthcare Quality and Payment Reform, they say that the vast majority of healthcare spending doesn't go to physicians. These scheduled payments represent only 16 percent of total spending in Medicare Parts A, B and D. Physician fee-scheduled payments over the next decade are expected to represent only 12 percent of total Medicare spending. However, physicians prescribe, control or influence most lab tests, images, drugs, hospital stays and other services that make up the other 88 percent. Does that sound correct?

Ms. Rivlin. I didn't quite follow.

Mr. Murphy. Well, basically that physicians' fees are a very small slice of that pie, but all the tests and everything else are the larger costs.

Ms. Rivlin. Yes. And the hospitals are the big cost centers in health care.

Mr. Murphy. And so the current system that is up there, I just want to get these points out to make sure we are looking into proper savings areas. Physicians lose revenue if they perform

fewer procedures or lower-cost procedures, even if their patients are better off. Would you say that is correct in the current system?

Ms. Rivlin. Well, that may be right, but as Dr. Moon was pointing out, there are a lot of things that could be better if physicians coordinated better.

Mr. Murphy. I agree. I want to get to that. Well, that is what I mean. For example, one area of coordinated care, we don't even have integrated electronic medical records. Behavioral medicine and physical medicine are just completely disjointed. And as a cap on, for example, psychiatric days, we don't do that for heart disease or diabetes and say, I am sorry; you are only going to get so many pills, or you are only going to have so many visits for your kidney problems. But persons who have a chronic illness double their risk for depression, very high amongst seniors, very high. Untreated depression and chronic illness doubles healthcare costs, but we keep ignoring this.

So would you see an alternative payment model for you and Dr. Moon that really looked at pushing and rewarding medical care to coordinate their care to really improve health as a way to get savings out of this system far more than what we are trying to squeeze out in some of these SGR things?

Ms. Rivlin. Yes, and I think you not only get savings; you get better medical care. You get better outcomes.

But it has to be said, the knowledge here is very much a work

in progress. We are learning how to do that. Accountable care organizations seem promising, and I would suggest we strengthen them, but we don't know all the answers here.

Mr. Murphy. Well, let me add one other thing here then. And that is that Medicare has a couple of times invoked some models that they said we want to do this as a pilot study, and sometimes a set of across-the-board changes that they have made with the DRGs or the RBRVS physician fee schedules, they have just done that. So should we also include here a mechanism whereby physicians could voluntarily go into an accountable payment system, so an alternative payment system, because not everybody will be ready for it, as an incentive to say, Let's move you toward this as a mechanism for reviewing this for the next year.

Dr. Moon, Dr. Rivlin, should we offer that?

Ms. Moon. I think something like that is potentially a good idea. One of the problems we still have, however, is that it is very spotty where these organizations exist and where there is the capability to do that. And when we think about rural or isolated areas, we also don't want to penalize physicians that are kind of trying to do it on their own and doing a very good job.

Mr. Murphy. That is why I say voluntary so that some who are ready can do it. Some who are not will need a few more years. That will give them more time but not force it upon them.

Ms. Moon. But I just hope that it doesn't become something that is cost neutral and you say we are going to take it out of

the hides of the folks who don't get involved because they may not be able to at this point.

Mr. Murphy. I understand.

Dr. Rivlin, final comment?

Ms. Rivlin. Yes. I think that is the spirit of what we are suggesting. Reward physicians who are willing to go into alternative payment mechanisms.

Mr. Murphy. Thank you.

I yield back.

Mr. Pitts. [Presiding.] The chair thanks the gentleman.

I now recognize the gentleman from Oregon, Mr. Schrader, 5 minutes for questions.

Mr. Schrader. Thank you, Mr. Chairman. I appreciate the opportunity.

To kind of follow up a little bit on Dr. Murphy's line of questioning with the Affordable Care Act, the incentives in there for incentive-based outcomes, for accountable care organizations, the coordinated care that I think is so important to really deliver the long-term health benefits, better quality care, as well as the big savings compared to all the other little things we are talking about and arguing about right now.

Could you talk a little bit about how the accountable care organizations and increased utilization of patient-centered medical homes, where the primary care physician gets involved, how that could actually help in generating a lot of savings for

Medicare going forward?

Ms. Moon. I think that coordination, as I mentioned, is the real key here. One of the things, the low-hanging fruit, obviously, is making sure that you don't duplicate tests, that you don't duplicate things that don't need to be duplicated. When you don't have good recordkeeping and transportable electronic records, that is a problem. You want to improve in that area.

You also want to try to encourage and find ways to provide the right incentives for the care to be delivered in the right place at the right time. And one of the things that we still don't quite know how to do is think about making that happen. Consider the example of bundled payment, where you are putting together payments to hospitals and post-acute care providers, like skilled nursing facilities and home health. Who do you put in control of that bundled payment? It probably makes a big difference in terms of then where the care is delivered. If the hospital is in control, more is going to be done in the hospital and less in the skilled nursing facility and home health.

So there are a lot of things that still have to be worked out, and we have to figure ways to coordinate care.

The other thing that I would mention that I think is really important and a challenge is how to get consumers involved. One of my big pet peeves is when people talk about a patient-centered medical home, and they don't really involve the patient. They simply say we will do what is best for the patient. Patients need

to be involved, not only to think about what care they need and don't need but also to cooperate and coordinate themselves to the extent to which they can. And we need to be realistic about it, but we need to get the patients involved.

Mr. Schrader. And that is where the primary care physician or healthcare practitioner or nurse practitioner can help make that actually happen.

Ms. Moon. Absolutely.

Mr. Schrader. Dr. Rivlin, with regard to some examples, you have talked again, just like Dr. Moon and Senator Lieberman, about good outcomes, value-based outcomes. The discussion has been, well, how did you measure that? Can you really measure value-based outcomes? I think the answer is obviously yes. Could you give us some examples of value-based outcomes that are, indeed, very measurable.

Ms. Rivlin. One success so far has been not rewarding hospitals when the patient is readmitted in a very short period. That is measurable. Maybe sometimes it is unfair, but it has had a serious effect on a hospital's being much more careful not to discharge a patient who might come back really quickly. So that is one example.

Mr. Schrader. I will give you several others too. My State, we have gone to the, we call them coordinated care organizations, and we include rural areas. It is not impossible to do that in a rural area, quite frankly, especially in this day and age of

telemedicine, where we have been able to actually drop the readmission rate in our hospitals anywhere from 10 to 20 percent. Stays for chronic obstructive pulmonary disease and heart issues, again dropping anywhere from 18 to 30 percent. Patient-centered medical home visits up 11 percent. So there are ways to -- I think it is important for the committee and subcommittee to understand there are ways to actually measure these things.

The last comment I would just make, Mr. Chairman, is while I agree that Congress historically plays loose and fast with what the pay-fors are, whether or not we actually do pay-fors going forward, I think is extremely important that we do pay for this. The near-term situation is such that while our Medicare costs are, indeed, going down, I think it is part of the ACA. It is undoubtedly part of the ACA. It is also undoubtedly part of the economy. But we can't rely on that with the math problem we have in this country. We have a tsunami of folks my age and a bit younger becoming senior citizens, becoming eligible for Medicare. And that is not going to be cured under the current deficit reductions we are seeing. It would be unconscionable for us to avoid addressing this problem. We are so close. This committee and the other committees have come up with a very excellent solution for going forward on the SGR. We are this close to coming together on it. I think Senator Lieberman made a good point. All the points are out there that we need to figure out how to pay for this, $140 billion, $144 billion is probably the

least costly fix to the SGR that we are going to see in our lifetime. And I would respectfully suggest that maybe the subcommittee, under the rubric of the committee, put together a task force to pick the least offensive ones.

We can protect the low-income folks. We came up with a definition in this committee of what we consider more low income. Certainly it is well below $250,000. I don't know if it is $85,000 or less, but we can figure that out. And I would really urge the committee to sit down and work together and figure this thing out because we are going to pay for it under this Congress. Time to get the job done.

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

Mr. Pitts. The chair thanks the gentlemen and now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

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

I appreciate it. Thanks for holding this very important hearing. I am constantly reminded about the importance that Medicare plays in the lives of my constituents when I am back in my district in Florida in the Tampa Bay area. In 2012, there were about 145,000 Medicare-eligible beneficiaries in my district. Medicare is an important program. I want to make sure whatever we do in Washington, that we protect current beneficiaries and future beneficiaries. We need to make sure that Medicare is on strong financial footing to be there for our parents, for us, and for our

children.

Senator Lieberman and Dr. Rivlin, in your Medicare modernization proposal, you talked about providing a unified deductible access across Part A and B. Can you talk about how this would provide clarity to seniors when understanding their Medicare benefit and discuss how this would reduce overutilization.

Mr. Lieberman. Thanks, Congressman.

Very briefly, it is actually very hard to describe the current system of deductibles under Medicare. It is so confusing. So I think the first benefit of combining Part A and Part B into a single deductible -- Senator Coburn and I recommended $550 annually -- is the clarity. And incidentally, in most private insurance plans, there is a clarity in deductibles. There is no reason why we shouldn't give the Medicare beneficiaries the same clarity. The second hope, obviously, is that as you create that clarity, you will create in the beneficiary kind of a second thought about overutilizing services. You don't ever want anybody to not go to the doctor or the hospital or get a prescription drug because they are worried about the cost, talking about hospitals and doctors in this combined deductible.

But there is clearly overuse. One of the more controversial recommendations that we made, but it has been included in some of the other studies done, is to limit the availability of the Medigap coverage because, for instance, not to have it pay for all

of the deductible and have it pay for a limited amount of the out-of-pocket because there is study after study that show that people who have Medigap use 25 percent more Medicare services than people who don't without any discernible increase in healthcare results. So, look, if we are going to solve this problem, everybody is going to have to help do it, including the beneficiaries, and this is a way to try to incentivize them -- not to stop going to the doctor or the hospital -- but to make sure they need to before they do.

Mr. Bilirakis. Thank you.

Dr. Rivlin?

Ms. Rivlin. Yes, I agree with that and especially would like to emphasize the part of that about Medigap. The effect of Medigap very often is to make health care free, and when it is free, you tend to overuse it. So putting some limits on that I think is important.

One other proposal that often goes with restructuring the deductibles is to put a limit on the out-of-pocket costs, which we don't now have. That goes in the other direction. It would cost something, but it would be a big benefit to especially low-income seniors who run up against high out-of-pocket costs.

Mr. Lieberman. That was one of the gives and takes -- excuse me, Mr. Chairman -- that Tom Coburn and I were involved in. So we did what we just did about the deductible and Medigap, but Tom agreed that we should put a limit on how much out of pocket a

Medicare beneficiary would have to pay, and that will have a significant -- real but also psychological -- effect on our seniors.

Mr. Bilirakis. Interesting.

I have one more question, Mr. Chairman.

Dr. Rivlin, in your testimony, you mentioned one idea was rewarding beneficiaries for using generic drugs. Can you elaborate on how to incentivize beneficiaries to choose lower-cost options?

Ms. Rivlin. Yes. I think it is -- often the beneficiary doesn't care whether the doctor prescribes the generic or the brand name. It doesn't matter to them. It should matter. They should pay a little less if the generic is prescribed.

Mr. Bilirakis. Thank you.

I yield back, Mr. Chairman. I appreciate it. Thank you.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentlelady from California, Ms. Capps, 5 minutes for questions.

Mrs. Capps. Thank you to Chairman Pitts and to Ranking Member Green for holding this important hearing.

I have long been a supporter of fixing the SGR. It helps providers and consumers alike -- it harms providers and consumers alike, the SGR. It keeps us from true innovation in the healthcare sector, but the conversation often stops right at the crisis point, how to make it to the next paycheck, and rarely

moves to one where we can really discuss our vision for our healthcare system in the future and how to get there. Last year we finally got everyone on the same page, both in the provider community and here in Congress, but despite the massive effort undertaken by many of us here on this subcommittee in the last Congress to come up with a solid plan to end SGR and once and for all set Medicare on a path toward improved quality and stability, we never made it to the last mile. In the end, it was political disagreements, not policy concerns, that kept us from the finish line. And I don't believe we can afford to do that again.

Mr. Chairman, I am a longtime member of this Health Subcommittee and a healthcare professional myself. And a permanent solution to the SGR problem must be our top priority, so I urge you to ensure that this hearing is but the beginning of swift action toward passage of a bipartisan, bicameral compromise legislation, agreed to last year by March 31, not just a box being checked before moving on to other matters. Anything less would be so unfair to Medicare patients, to the provider community, and to all who put their differences aside, which we did last year to find a strong policy compromise.

I would like to also take a moment to remind the chairman and my colleagues that while SGR, the replacement policy for SGR, should not be reopened, we shouldn't forget the additional policies that need to be included with this bill. Commonly known as extenders, these programs, like lifting the Medicare outpatient

therapy session cap and extending the qualifying individual programs that help low-income seniors afford their Medicare premiums, these are all critical to ensuring the strength of the Medicare system and must not be forgotten.

And I have a concern that some of the conversations here today represent a step backward in finding a permanent solution, and I think we need to be clear. Reform the SGR on the backs of seniors and persons with disabilities who receive care is one of those damaging conversations.

Now I have a question for you, Dr. Moon. We have heard a number of proposals that would reduce the Medicare benefit for those currently on the program or even eligible for Medicare. For example, Mr. Lieberman mentioned in his testimony that his proposal would gradually raise the Medicare eligibility age from 65 to 67. We have heard this proposal from leaders on the other side of the aisle as well.

And I want to be clear about my view: This is a bad policy. It is shortsighted, and its consequences are so far reaching. It would break our Nation's longstanding promise to its people that if you work hard and pay into the system, it will be there for you when you turn 65. It would raise healthcare costs for these individuals at a time when they are most often in need of saving.

In fact, the Kaiser Family Foundation estimates that two-thirds of 65- and 66-year-olds -- and that is 3.3 million people -- would have to pay on average $2,200 more dollars for

coverage than they would if they were on Medicare. So I would like to ask you, Dr. Moon, to speak to the policy effects of raising the Medicare eligibility age.

Ms. Moon. Congresswoman, I agree with you that raising the age of eligibility has a lot of problems, particularly for the modest-income individuals who would find it difficult to afford that. Higher-income individuals now actually are pretty well taken care of by this because we have a Medicare secondary payer program in which if you have insurance through your employer and you are still employed, Medicare is secondary, and it is not very costly at all.

Moreover, you would keep eligible those who are disabled in the program who are 65 and 66, and they are the expensive folks, so you wouldn't save very much money, but you would put at considerable risk folks who wouldn't qualify for disability, wouldn't qualify for low-income protections, and would have to pay these substantially higher premiums to get their insurance somewhere else.

Mrs. Capps. Thank you. You know, I have a Kaiser Family Foundation chart here that I would like to submit for the record that shows that Medicare beneficiaries aged 70 and over account for 63 percent of Medicare spending, with persons with disabilities accounting for another 22 percent. Aren't most of the costs in Medicare programs generated by those older than 67?

Ms. Moon. Yes, they are, and when you take the 65- and

66-year olds out of the program, the other thing that will happen is the premiums will go up in Medicare for everyone else because you are taking inexpensive people out of the program and leaving only the more expensive people in the program, another unintended consequence.

Mr. Pitts. Without objection. We will enter that into the record.

[The information follows:]

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

Mrs. Capps. Thank you very much.

Mr. Pitts. The gentlelady yields back.

The chair recognizes the gentleman from Indiana, Dr. Bucshon.

Dr. Bucshon. Mr. Chairman, I was a practicing cardiovascular and thoracic surgeon for 15 years prior to coming to Congress, so, first of all, I would like to say I am grateful to be on the committee and on the subcommittee and discuss this very important topic.

Briefly, I am going to comment on another thing that we are not really talking about today but to help the Medicare program is to really get overall healthcare costs, bending the cost curve; price transparency; quality transparency; work towards a more market-driven economy in health care versus a price-fixed economy; of course, tort reform to decrease the cost of defensive medicine, among many others. Coordination of care is very important, including coordinating medical records, electronic medical records, to be able to communicate with each other. This is a significant problem even within my own community.

With that, Dr. Rivlin, in Senator Lieberman's testimony, he states that if we do nothing, Medicare Hospital Insurance Trust Fund will become insolvent at some point in the next decade. That means it will have exhausted its reserves, and it will pay out more in claims than it receives in taxes. As a former CBO Director, how real do you take this threat if Congress fails to act to improve the financing of the Medicare program?

Ms. Rivlin. Oh, it is very real. Now, there isn't an exact drop-dead date. We change that estimate every year, depending on how rapidly costs are going up, but it is clear that on almost any trajectory you can imagine, that we will not have enough revenues coming in to support the current program for beneficiaries. Now, that doesn't tell you what to do about it, but it is a real problem.

Mr. Bucshon. And what might be the result of that to seniors? Say that did happen, the next day, what would happen? What would be necessary with the program if we didn't change it and it got to that point?

Ms. Rivlin. Well, you are assuming that Congress doesn't do anything. The Congress would do something, but it would be more expensive to wait than to gradually phase in the kinds of reforms that we have been talking about today, which we all hope will make the health system more efficient and give the beneficiaries of Medicare better care for less money or less rapidly increasing costs.

Mr. Bucshon. The Congressional Research Service in a memo dated April 16, 2012, opined on what would happen should Congress fail to address the coming bankruptcy or insolvency date of the Medicare Hospital Insurance Trust Fund, and I quote, There are no provisions in the Social Security Act that govern what would happen if insolvency were to occur. For example, there is no authority in the law for the program to use general revenue to

fund hospital services in the event of a shortfall. Plainly put, Medicare is not authorized to pick which claims to pay and which not to pay in the event the program no longer has funds to cover overall costs.

Senator Lieberman, on that point, which I think is very important, if we do nothing, the Medicare Hospital Insurance Trust Fund will become insolvent. The Congressional Research Service says that there is no authority for Medicare to pay hospital claims in the event the program does go insolvent. I think you will probably agree with Dr. Rivlin that the problem is real, but how might this impact if there isn't action, how might this impact access to health care for senior citizens?

Mr. Lieberman. Thanks, Doctor.

The problem obviously is real statistically, as Dr. Rivlin said, under almost any imaginable set of scenarios. This prospect, Dr. Rivlin is probably right, in an atmosphere as we got up to midnight and it looked like the Hospital Insurance Trust Fund was going bankrupt, Congress would probably come in and fix it. But you just think about the instability that would cause in our healthcare system and the high anxiety it will cause among seniors. So this is a question of whether, like so many, whether Congress and the Executive work together to solve a problem before it becomes a crisis or a catastrophe, because, inevitably, that is what is going to happen. The people that have spoken today I respect. Obviously, to fix this you have got to ask people to do

things they don't want to do.

Dr. Coburn and I, I think, came up with a proposal that was ultimately pretty progressive and tried to share the responsibility for avoiding the catastrophe that you described. If that catastrophe was not on the horizon, of course, none of would do any of this. We would just keep going along, but that is putting our heads in the sand, and that is not what I know any of you came here to do.

Mr. Bucshon. I think we can make the case for incremental reform, and the SGR proposal may be a great opportunity.

I yield back.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes of questions.

Mr. Pallone. Thank you, Mr. Chairman.

I have been going back and forth between the other subcommittee; so I apologize for that. But I do want to state for the record that even though I have a "D" next to my name, I do not associate myself with the comments of two witnesses here today. While I respect their prerogative to be here, I don't believe that we need to cut Medicare any further, especially on the backs of seniors. Robbing Peter to pay Paul is how I coin it, and I am deeply opposed to many proposals discussed here today. If we insist that we have to pay for the SGR fix bill, revenues and other offsets outside health programs should be on the table.

And, unfortunately, all too often around here, our health dollars are used to pay for nonrelated bills, tax bills in fact, and the reverse should be the case.

So, Dr. Moon, if I could ask a question, my Republican colleagues have proposed keeping tax levels at about 18 percent of GDP, which is in line with the average level 60 years ago. What we have known about the aging of poor populations and the increasing need for healthcare coverage under Medicare, which I might point out is a demographic problem, not a cost control problem, is it realistic to keep revenues at that level? That is my first question.

Ms. Moon. I don't believe that it is realistic to keep revenues at that level if your goal is to have a healthy and viable Social Security, Medicare, and Medicaid program that serves this population.

Interestingly, if you look at polling of citizens, they all say they are willing to pay additional taxes to make sure that these programs remain healthy. We also know that when Medicare was passed in 1965, people talked explicitly about the fact that there was going to be an aging of the population. The worker-to-retiree ratio was going to change. This was all known, and what was said at that point in time is that revenue increases would be necessary. Payroll tax rates would have to go up. Because they did not want to have them be so high in the beginning to be a drag on the economy, they thought this was better to be

done in gradual increments over time.

I believe that revenues need to be thought of as part of the package. I believe, even though I am a very strong supporter of beneficiaries and protecting the beneficiaries, that as a society, we think about what is the fairest way to ask people to pay for programs that we value as a society. And if that is partially from beneficiaries and partially from revenues, I am fine with that, but I think taking one side off the table and saying we are not even going to discuss it is very poor policy and not what the American public really wants to see happen.

Mr. Pallone. Well, thank you.

Let me ask you another question. In Congress we have been passing these so-called doc fixes to the SGR for more than 10 years. We have been patching the SGR for so long that the Congressional Budget Office doesn't even take seriously the possibility we won't. Is it fair to say that the SGR has become a budget gimmick? Isn't it more fiscally responsible to pass the repeal-replace legislation without paying for it than to not pass it at all?

Ms. Moon. Well, in many ways, that becomes a political issue. When I look at what Part B is all about, it says that you are supposed to pay for Part B out of general revenues and premium increases from beneficiaries as the costs go up over time. That will happen naturally if you change the SGR. There is nothing in the law -- people want to talk about the law and the trust funds

and so forth -- that require you to pay for it.

If as a Congress the Congress decides it wants to pay for things going forward, I don't have a problem with that. My problem is then to say that it can only come out of beneficiaries as a solution I think is way too narrow a reading of what is good public policy.

Mr. Pallone. Let me try to get this last one in. My Republican colleagues insist that we pay for the SGR repeal. However, they had no problem voting to increase the deficit when it was politically convenient. For example, last week they passed another ACA, you know, the 30-to-40-hour rule that would cost $53 billion. And they didn't pay for that. And more than 50 times, they repealed the Affordable Care Act. And that would have cost the country more than $100 billion each time. So these doc fix patches have cost the American people $169.5 billion more than the $144 billion cost of the bipartisan, bicameral repeal. If we don't do our job and pass the SGR repeal, how much more money will be wasted that could have been used for the permanent fix?

Ms. Moon. Kicking the can down the road, as people have said, and having only temporary fixes is a really poor way to do policy. It is the absolute worst of all possible options, I believe. On the other hand, you also don't want to see the SGR go into effect and slash payments to physicians and have people defect from the Medicare program. A question, I think, that you raise is a very legitimate one in terms of what is most important

and how to achieve change. Just as I am opposed to having beneficiaries pay, I also think good policy means you do need to look at what you are going to do instead of this because we do make these decisions that affect health care going forward, but I think that there are a lot of solutions that one could look at and a lot of changes that need to be looked at, not as a way to pay for another fix but as policy unto themselves. If we think that raising taxes, there is a good reason to do it for some purpose, if we think that cutting benefits has a good purpose, those should be done on their own merits and not just because you are using them as an excuse to get another desirable policy change.

Mr. Pallone. Thank you.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentlelady from Indiana, Ms. Brooks, 5 minutes for questions.

Mrs. Brooks. Thank you, Mr. Chairman.

I happen to be one of the members of this subcommittee that does believe we need to explore ways to pay for this, and I would like to start out with Dr. Rivlin, because based on the breadth of your experience and your time working as an honest, data-driven policy expert and studying bipartisan manners of doing things, what would you say is the best chance and the best package that we could put together in a bipartisan way to pay for the offset of the SGR? If you could be queen for the day and pick -- and I know

you have mentioned a few things already -- but if you could put together the package that you would like to see us start with, what would be in that package, Dr. Rivlin?

Ms. Rivlin. Well, there would be quite a few items, and I would put in the increasing premiums at the high end. I would put in accelerating the transition to -- accelerating the incentives to payment reform that I think is good in itself and would generate the savings. And I would put in rewarding the use of generic drugs more. I would put in more competition, competitive bidding, starting with lab tests, but you can use competitive bidding in quite a lot of things that Medicare providers buy. But I would put the biggest emphasis, I think, on the transition to alternative payment models because that is not on the backs of beneficiaries. Beneficiaries will benefit if they have better coordinated care and care that is directed toward outcomes rather than just more services.

Mrs. Brooks. And I am glad that you emphasized that at the end because the proposals that you put forward would not be to the detriment of beneficiaries in your studies. Is that correct?

Ms. Rivlin. Yes. Except for the increase in premiums, I don't think the things that we are suggesting are on the backs of beneficiaries, as you have said.

Mrs. Brooks. And, Senator Lieberman, knowing the congressional calendar the way that you do and based on your experience, and you have more experience -- I am just starting my

second term -- negotiations on something as complex as this, binding the office offsets we believe necessary to pay for SGR -- most of us believe -- how important is it that we begin to work now on this, and what advice would you have for this subcommittee and how we should accomplish this task?

Mr. Lieberman. Thanks very much for the question. I mean, obviously, the sooner the better because the session moves on, but also you are facing the SGR deadline, which will be another crisis, and you will be into another time when people will be attaching all sorts of things to it and holding up action. And meantime doctors and beneficiaries will be very anxious about what is going to happen, so I would say the sooner the better.

The second is to acknowledge as you begin to negotiate that you have achieved something quite significant and a bit unusual in the current mood in Congress, which is you have agreed on an SGR replacement and reform. I would say that to finance it, I personally have said that I think you have to offset it, and, frankly, beyond the philosophy or ideology of it, I don't think it is going to pass if you don't offset it so you have got to deal with that reality. And then it is a question of finding a balance of ways to do so.

Incidentally, the proposal I have talked about, it doesn't only, it doesn't even primarily build on asking beneficiaries to do more. It asks people based on their income to do a lot more. I think one thing that is missed here, Mr. Chairman, Mr. Green, is

that in the current situation, most people don't realize -- but I know the Members do -- that most of Part B, doctors' insurance, 75 percent is not funded by payroll taxes; it is funded by general revenue. And more than 80 percent of Part D, prescription drug, also funded by general revenue, tax revenue. That is fairly progressive, but it also hits a lot of middle-income people. Therefore, it is not as if, if you don't do something here to ask a little more of beneficiaries and more of people of higher income, that the money is just going to come down from heaven. The general taxpayers are going to be paying more than their fair share.

Look, you have been all through this. When the system works, people put the national interest ahead of everything else, and their constituents interest even though it is not short term, which this program is going to go belly up unless there is a compromise agreement to save it.

Mrs. Brooks. Thank you. Thank you for continuing to care and to share with us your advice.

Thank you. I yield back.

Mr. Lieberman. Thank you.

Mr. Pitts. The chair thanks the gentlelady.

I now recognize the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for questions.

Mr. Kennedy. Thank you, Mr. Chairman.

Thank you, Ranking Member.

And, once again, thanks to the witnesses for your testimony. Thank you for your service and all the work that you have dedicated to these important issues. Thank you for sticking around so long this morning.

It is a nice thing to do when you get all the way down to this end. So I appreciate it.

Dr. Moon, there have been a number of comments today and we have heard from a number of folks, both elected officials and policymakers, that have suggested that the financial Outlook for Medicare is bleak, that it is potentially near bankruptcy, indicating that without urgent action, the program won't be financially solvent in the near future. That has been at times used to justify some pretty significant cuts to the program. Can you help us understand the financial health of Medicare and what fiscal challenges and what kind of time frame we are looking at in terms of ability for current Medicare revenues and the Medicare Hospital Insurance Trust Fund to continue to cover the cost of the program?

Ms. Moon. The Medicare program and the Social Security program are both very different than other parts of the Federal budget because we look 75 years ahead and try to figure out what is happening in these programs. Technically speaking, the spending on defense faces insolvency at the end of this fiscal year because you have to fund it. That is not the case for Medicare and Social Security, and in many ways, I believe the

trust funds were established to try to be an early warning device and not as a bludgeon to say, you are going to have to cut the program, but rather to say, what does it look like it will take to continue forward with the program?

Then it is totally legitimate to ask when that outlook becomes bleaker, what should we do? Should we raise taxes? Should we cut benefits? Should we find others ways to change the program to improve it. I don't think anyone here would disagree that if you could find ways to make Medicare more efficient and more effective, we should do that in a heartbeat. The question is when you have done that as much as you can, then who do you hold accountable? Do you say, beneficiaries, you are the ones on the hook for this, or, as taxpayers, we are also on the hook for this, and I believe it has to be a shared responsibility. I believe, therefore, that it is convenient sometimes to talk about the trust fund as forcing us into action, and that can be used very effectively. It can also be used to justify poor policy as well in an emerging situation.

It is also the case that the trust fund balance looks better and worse. I was a public trustee from 1995 to 2000, and my husband always likes to say I saved the program, that it went from 4 years before bankruptcy to 37 years. And it had almost nothing to do with me. It had to do with policy changes that were made, most of them in terms of improving the program over time and not penalizing beneficiaries.

Mr. Kennedy. Just kind of bouncing off that for a second, Doctor, and some comments by the ranking member of the committee, Mr. Pallone, and actually Mr. Schrader as well, both of whom, and I am sure others have as well, mentioned the impact of the Affordable Care Act on the solvency. Could you discuss that a bit? And I understand that the trust fund is now in good standing for an additional 4 years out to 2030, given current estimates. But given the fact that there have been some savings realized, particularly over the past several years, forecasting that forward, what do you anticipate?

Ms. Moon. Forecasting forward is always very difficult because there are a lot of things that can happen. No one expected Medicare to slow down as much as it did, although it was kind of a happy combination of several things -- or an unhappy combination, I might say, in terms of the poor health of the economy certainly contributed as well as these reforms that we think are important.

I believe we are on the cusp of making major changes in health care because we have to. Health care is expensive for everyone, not just for the Medicare program, but for all of us who use healthcare services. We need to get those costs under control. And I believe that we are now serious as a country about doing that. The ACA put in place a lot of reforms, not all of them aimed just at Medicare but aimed at changing the healthcare system overall that show promise and are supposed to be

evidence-based in moving forward. There are going to be fits and starts. Some of them are going to work well. Some of them are not. We are not going to be able to put anything on automatic pilot. We are going to have to keep working at it.

But I am reasonably optimistic that we are going to find ways to keep the costs of health care within bounds over time and that the health of the trust fund will look pretty good even if we don't do a lot of other things except work on these reforms over time.

Mr. Kennedy. Thank you, Doctor.

My time is up. I yield back.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentleman from Texas, Dr. Burgess, 5 minutes for questions.

Dr. Burgess. Thank you, Mr. Chairman.

Again, thanks for doing this hearing so early in the new term.

Senator Lieberman and Dr. Rivlin, let me just ask you a question because I wasn't here when Medicare started. I am not implying that either of you were.

Mr. Lieberman. I want to be clear that I wasn't either.

Dr. Burgess. But my study of the situation, the Medicare Part B premium was originally 50 percent and was later reduced by Congress to 25 percent. Is that not correct?

Mr. Lieberman. That is correct.

Dr. Burgess. There has already been a major adjustment as to where those moneys actually come from. I do want to add just that it has been brought up by several other Members, but I think it is important that we pass this. It was important last year. I regret very much that the Senate did not attach as much importance to it as the House did. I think there was a real opportunity that was missed last year, but it is up to us to make our own opportunity this year. We do have to get to 218 votes in the House. Last March, we got a vote on the repeal of the sustainable growth rate, the essential policy that I already referenced, and it attracted every Republican vote and two dozen Democrats. It was a significant vote. That path to 218, I believe includes a path that is offset. And the overseas contingency operation money, maybe, maybe not, but I think those contingencies overseas are actually happening even this morning so that money may, in fact, no longer be there.

Senator Lieberman and Dr. Rivlin, you have both been there; Dr. Rivlin, in the administration, and Senator Lieberman in the Senate. You have been there when big deals were done, when hard things were done, hard legislation was passed, and people had to come to agreements and compromises. Do you think that with what you know of where we have been already with this, isn't it now time to get that deal done and to get those compromises done? Can you foresee a path forward where this one can actually move?

Ms. Rivlin. I can. I am also an optimist about these

things, but there are many examples, welfare reform, for example, wasn't anything that either side exactly loved, but it did get done. And I think you are at that moment when you could have the advantages of fixing the SGR and also putting the whole health system on a better track.

Using the overseas contingency fund seems to me to forego the opportunity that you have to pay for the SGR repeal with pay-fors that are actually good health policy. That is what you ought to be looking for, and I think there are quite a large number of them.

RPTR HUMISTON

EDTR SECKMAN

[12:17 p.m.]

Mr. Lieberman. Thanks, Congressman.

It seems to me that, again, I repeat, you have taken a big first step in the agreement on SGR replacement. Now, in a way, you are at the hard part, which is, how do you pay for it? But if you have got the will, you can do that. There are all sorts of ways to pay for it reasonably.

Now, the reason I am proposing that, you know, if I may cite again the philosopher of Chicago, Mr. Emanuel, "A crisis is a terrible thing to waste." You have got a crisis here --

Dr. Burgess. That actually didn't work out for us so well.

Mr. Lieberman. Yeah. No. I remember that. I was hoping your memory was short, but the reality is that -- let me cite these numbers that really struck me when I was working with Senator Coburn. So our proposal was estimated by the various authoritative groups to save between $500 billion and $600 billion over 10 years, but here was the stunner: $10 trillion reduction in the 75-year projection of unfunded liabilities of Medicare.

So if you use this SGR crisis, if I can refer to it that way, and then fund your answer to the problem, your solution to the problem, with some Medicare reforms you can agree on, then you are going to have an -- you are not only going to solve that problem,

you are going to have an enormous long-term effect on the viability of the Medicare fund.

And, look, the public is -- it is sort of unconventional politics. Maybe I see this more from outside than I did inside. I think the public really wants Members to do things that aren't conventionally political, and say no to some groups but say yes to the future of Medicare, to the future of the country, in the sense that it is not going to be burdened by unbelievable debt.

Dr. Burgess. Dr. Rivlin, I just want to point out that along the lines of being an optimist, I have introduced an SGR repeal every term in Congress since 2003, even --

Ms. Rivlin. Good.

Dr. Burgess. So we only had to push one stone up one hill.

Ms. Rivlin. Someday it will happen. Maybe this day.

Mr. Lieberman. You deserve a medal.

Mr. Pitts. The gentleman yields back.

The chair recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. Castor. Well, thank you, Mr. Chairman.

And, Mr. Chairman, and, to Ranking Member Green, thank you very much for making this one of our first hearings of the new session.

There is nothing more nonsensical than the SGR patch from year to year by the Congress. It is absurd. And we need to act now to permanently repeal it. And time is of the essence, because

the current patch runs out at the end of March. And I am heartened, because we did have a bipartisan bill last term. We came very close. And we need to work together to get that bill on the floor and fix this once and for all.

That bill is important, because it repeals the SGR and it establishes a new framework for reform, what Dr. Rivlin has said, more efficiencies, and Dr. Moon says, a greater coordination of care. It simply now begins to transition Medicare from a volume-based system to one on value, coordinating care, the new medical homes. We are smarter now. We have learned the lessons of the past, and we need to put them to work.

I would encourage my Republican colleagues, as they move towards the budget season, that they dispense with the very simplistic balance sheet policy that says Medicare should be a voucher system or premium support, because it simply shifts the cost to the beneficiaries; it does not solve the overarching issues of what we have learned over time. And it is an important -- in reform, the much more difficult piece is going to be reform. And it is not one size fits all. It is pharmaceutical costs. It is working to weed out fraud and abuse. It is a lot of the ideas that have been floated today, but one idea that was floated that I think we need to set the record straight on right now is that asking beneficiaries to put more skin in the game, whether it is the Medigap or others, is going to save us money, because I know a lot of economists believe beneficiaries need to

have more skin in the game, but the National Association of Insurance Commissioners reviewed the literature just recently and put together an expert analysis. They were unable to find any evidence that cost sharing encouraged appropriate use of healthcare services. In fact, they found that cost sharing would result in delayed treatments that could increase cost and result in adverse health outcomes.

Dr. Moon, are you aware of this analysis? And do you agree --

Ms. Moon. I am aware of this analysis and analyses that go back many, many years to where what you find in many cases is the way that cost sharing works is it pushes costs onto someone else. And if they can't afford to pay, then they don't get the care.

It very seldom discourages use of unnecessary services. It, like the SGR, is a really broad-based penalty, where you are trying to discourage behavior that is a much more subtle behavior. You don't want people not to go to doctors. You want people not to get unnecessary care. And to have an across-the-board requirement that people pay X percent or put certain amount of skin in the game just doesn't get you there.

And, in particular, remember that most healthcare spending is for people once they are well in the grips of the healthcare system, and they are not asking any questions about use of services. Those are the very sick. Those of us who are healthy account for such a trivial part, that having us be a little bit

savvier consumers just doesn't really work out.

Cost sharing just is a pretty unsubtle mechanism to use. There may be times when you use it, and we certainly use it because we are asking people to share in the costs of healthcare, but let's not assume that it is this subtle mechanism. It is simply saying, we are going to ask you to pay more instead of us.

Ms. Castor. Thank you very much.

And I would like to ask unanimous consent, Mr. Chairman, to submit into the record the analysis and letter from the National Association of Insurance Commissioners on the topic. And America's Essential Hospitals also have submitted a letter for the record.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

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

Ms. Castor. And I will just make one final point before I close, and that is to really encourage my colleagues on the Republican side. We were so close last year, and the SGR repeal was combined at one point with one of the -- how many, 50 -- in the series of repeal of the ACA, wholesale repeals. This is too serious to do that again. We are ready -- we are so close. And the longer we put it off, the more expensive it will be, so I will encourage us to get to work and really shoot for resolution by the March 31st deadline.

Thank you, and I yield back.

Mr. Pitts. The chair thanks the lady, and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. Shimkus. Thank you, Mr. Chairman.

And I also want to thank you for staying a longer period of time. I am a fairly senior Member, but I didn't get here on time, so I got pushed down to the bottom.

In fact, Senator Lieberman, I was here in 1997 when we attempted to balance the budget, and the SGR arrived.

Mr. Lieberman. Right.

Mr. Shimkus. And we have been fighting the battle ever since, so I am part of the problem of where we are at today.

Mr. Lieberman. Both of us are.

Mr. Shimkus. And so I thought -- Tom Coburn served in this committee when he was a House Member, and we know him well.

And, Dr. Rivlin, I was one of the 16 Republicans who

supported the Simpson-Bowles --

Ms. Rivlin. Good.

Mr. Shimkus. -- vote that we had on the floor. There was only 38 Democrats who supported that, and 54. Just shows you the challenges we have.

Mr. Lieberman. Right.

Mr. Shimkus. I always put a chart up on the screen. It is a budget chart; I think it is 2013. And it just highlights what you all know and the message that we have got to continue. I think former chairman of the Joint Chiefs of Staff said the debt is a threat. Now we are at $18 trillion. So when we have these government shutdowns and battles, it is only on the blue portion. The red is running uncontrolled. It is an entitlement system, mandatory spending; it is things that we don't get control over.

So I just think it is wonderful that you are here, because the proposal is, if I understand, listening to a lot of great questions, is that we have an opportunity to use the SGR debate and tweak the mandatory spending, or the entitlement side, which has to be done. We just can't no longer continue to go down this path. And I do think there are people willing to, but I was talking to Dr. Burgess, and I asked him, do you really think we could tie these two together? And you hear some of my colleagues, no, don't touch it. Let's fix SGR. We will live to fight on the mandatory spending another day.

So insurance companies would do actuary tables. They would

look at the amount of money they would have available to meet their obligations. So the question is tweaking that. And the benefits are really long term.

I think, Senator Lieberman, on your opening testimony you said -- well, you mentioned $10 trillion down.

Mr. Lieberman. Yeah.

Mr. Shimkus. That is not chump change. That is real money here in Washington these days. So one of the simple questions is -- and again, and, Senator Lieberman, in your testimony, you mentioned the Social Security Administration. There are, like, a lot of seniors whose annual income is over $1 million, so can't we ask them to pay a little bit more into the Medicare beneficiary that they are receiving if they are taking that? I don't think that is -- I don't think that is out of line. In fact, these entitlement programs are for the most needed. There is always this debate. Well, they paid in it, they are entitled to it, so they get it, regardless of how many have been blessed by this country and the largesse of their ability to accrue wealth, and I think we better have it for the poor.

Senator Lieberman?

Mr. Lieberman. Oh, I -- look, we should ask the wealthy to pay more. And in the proposal that Senator Coburn and I put forward, we did ask the wealthy to pay more. Frankly, it is still -- Medicare is still a better deal than they could generally get in the private sector.

And, again, I would say that because Part D and Part B are mostly paid for by general tax revenue, and I will -- a disproportionate share of the general tax revenue comes from the wealthy. They are paying for a lot of the program. But I do want to come back to what I said: It is not as if the current system is fair to everybody. The middle class is also paying a lot of taxes, and those taxes are paying for most of Part B doctors and Part D prescription drugs.

So sure, I mean, it is consistent with our whole system. We should arrange to fix this in the fairest and, dare I use the word, most progressive way we can.

Mr. Shimkus. And, Dr. Rivlin, you talked about how raising taxes might be counterproductive in your testimony. Did I read that correctly?

Ms. Rivlin. I don't remember saying that, but I am not in -- I am in favor of more revenues, actually, in general, but in a balanced way, in the way that we did in Simpson-Bowles and the Domenici-Rivlin plan, which involves major tax reform, getting rid of many of the loopholes that benefit upper-income people. If you do that right, you can actually lower the rates.

Mr. Shimkus. Right. Right. Well, again, I -- these are debates that I have been yearning for, for my now 19th year of being here in Washington. It is -- we just can't hide underneath the rock. And I am glad you have come, and I look forward to working with you. Thank you very much.

Mr. Lieberman. Thanks, Mr. Shimkus. Seize the moment.

Mr. Pitts. The chair thanks the gentleman, and now recognizes the gentleman from New York, Mr. Engel, 5 minutes for questioning.

Mr. Engel. Thank you very much, Mr. Chairman, and thank you for holding this hearing.

And congratulations to Mr. Green for being in his position. And I want to thank all the panelists for really good testimony.

My good, dear friend Joe Lieberman and Dr. Rivlin, Dr. Moon, thank you so much.

You know, what strikes me -- because the questions I had to ask have long since been asked and answered -- what strikes me in listening to the panel is you are all saying different things, but you are also really saying the same things. And I really agree with much of what each of you has really said.

Dr. Rivlin, you just finished the last question with something I was going to ask. You know, yesterday President Obama spoke at the State of the Union and talked about a middle class tax cut and he talked about funding colleges, community colleges, with free tuition. And I agree with both of those proposals. And he said that in doing that, he would get the money by asking the very wealthiest to pay just a little bit more.

You, Dr. Rivlin, just spoke about general tax revenues.

You know, it seems to me there is a lot here that we all agree on both sides -- on both sides of the aisle. We recognize

that the SGR needs to be repealed and reformed, that it needs to be fixed permanently, and that this is a very good opportunity to fix Medicare. Joe Lieberman, I think, laid out a compelling case about if we just do nothing, we are really going to be in trouble.

And if we are going to be honest with each other, my colleagues, there is plenty of blame to go all around. On this side of the aisle, we won't even look at some of the things that people say we need to have if it is going to be balanced. And on the other side of the aisle, you won't even consider any kind of tax increases whatsoever. And the truth of the matter is we have to take our blinders off and kind of look and see.

I agree that the beneficiaries should not bear the major cost of it, but I wonder if you could, Dr. Rivlin, just elaborate a little bit on what you started to say in answer to the last question about general tax revenue, about changing some of that to get more money into the Medicare program.

Ms. Rivlin. Well, I favor, as I said, comprehensive tax reform, and I think you can do that in a way that raises more revenues and is more progressive. That is an okay term. But I would caution this committee against getting too far afield. You have already done a really constructive piece of work in this tri-committee bill. Strengthen it; and pay for it; and pay for it in a way that accelerates the payment reform in Medicare and makes Medicare a more efficient program. And you can find various ways of doing that, but I wouldn't take on the burden of reforming the

whole tax system in this context, because you have got a big opportunity to do something very important right here in this committee.

Mr. Engel. Well, I do think that if we are really going to hopefully down the road have a much greater fix, that we are going to have to talk and be honest about general tax revenues.

Senator Lieberman, I am wondering if you could elaborate a little bit more on, in your proposal, general tax revenues were not a part of this. Is there a reason why? And do you think we could combine the two --

Mr. Lieberman. Right.

Mr. Engel. -- and perhaps come up with a --

Mr. Lieberman. Well, we were -- it is a good question. Thanks, Congressman.

We were working really as best we could within the system, so we added some progressive elements to it. I mean, we asked the people, based on income, to pay more for Part B and Part D. We set a limit of out-of-pocket expenses for people at $7,500, which was something I appreciated very much that Dr. Coburn was willing to support, but we raised that up to $22,500 for individuals who make more money. So we tried to be comprehensive about it, but I think the other thing that has to be recognized -- I repeat myself, and I apologize -- is that it is general revenues that are paying for most of Part B doctors and Part D prescription drugs now.

I am not against, you know -- the system is a fairly progressive system now, not just the Medicare financing but our tax system overall. I am not against tax reform that in some ways makes it more progressive. But that has to result from a give and take in which both sides feel that they are getting something that they believe in.

Mr. Engel. And, you know, just in conclusion, the truth of the matter is, I believe there are a lot of people on both sides of the aisle that have political courage to do the right thing, but you want to have the political courage and do the right thing if you know it is real.

Mr. Lieberman. You know it is real.

Mr. Engel. It is real.

Mr. Lieberman. I agree.

Mr. Engel. If you have political courage, but it is not real, it is really a lose-lose situation.

Mr. Lieberman. Yeah.

Mr. Engel. And I think, I hope that we can make this real, because we do know that this can't continue, and we don't want to hurt the beneficiaries. Thank you.

Mr. Lieberman. I agree. I mean, it is great to see Mr. Kennedy here. There are some familiar names: Sarbanes, Matsui, Kennedy.

But, you know, Teddy used to always say that, with his members of his committee particularly in the last period of his

life -- Mike Enzi, pretty conservative Republican -- if we agree on 60 percent or 70 percent or 80 percent on this given issue, let's do it. Let's forget about the other 40, 30, 20 percent. And President Reagan said that too. He would much rather get 50 percent of what he wanted rather than sort of hold his flag high while he was going over the edge of a cliff. That makes a lot of sense.

Mr. Guthrie. Thank you.

The gentleman's time has expired.

I recognize Mr. Griffith from Virginia.

Mr. Griffith. Thank you, Mr. Chairman. I appreciate it. This is a marvelous panel. I appreciate listening to your testimony here today. I am proud of the work that we have done over the last 2 years, and hopefully we can finish it up this year.

One of the champions in that cause in leading the way has been Dr. Burgess of Texas, and I accordingly now yield my time to the good doctor.

Dr. Burgess. Well, I thank the gentleman for yielding.

I just have a couple of follow-up things that I wanted to cover. And it is really too bad that Mr. Shimkus has left, because I wanted to give him some comfort that this actually --

Mr. Shimkus. I am watching you. I have got your back.

Dr. Burgess. -- that some of the changes that led to the SGR were actually implemented in Congress in 1988, and that led to the

update adjustment factor that got us into some of this mess where we are. So I wanted to alleviate that burden from my friend from Illinois because I know he carries it around, and it is a very heavy burden.

I also want to address the issue of, you know, we talk about how Medicare spending has been reduced. And, in many ways, it was a pleasant surprise in January of 2013 when the CBO came out and said, Hey, we put SGR repeal on sale. After the 2012 election, I had put a lot of hope in the fact that Governor Romney was going to win the election; Paul Ryan would be the vice president; we would have a full-throated implementation of premium support; and, over time, the SGR argument would simply go away, because premium support would replace it, there would no longer be a need for the SGR. Well, that didn't happen. But then the Congressional Budget Office came to the rescue of SGR reform and put it on sale.

But, yeah, the recession may have caused part of that. The SGR itself may be responsible for some of the reduction. The Affordable Care Act, yeah, you know, it hadn't really been implemented for all that long. But, 10 years ago, Part D happened, and a lot of us argued prior to the passage of Part D that, hey, if we pay for the Lipitor, there may be fewer episodes of congestive heart failure requiring hospitalization. And it is, in fact, the -- and I have not seen any study now of the 10-year effect. We actually -- here is an interesting point. We are almost at the 10-year point of the implementation of Part D. Has

anybody gone back and looked at what were the actual savings? We were all told what it was going to cost. It didn't cost that much.

But there were actually some benefits, because when Medicare originally passed, it paid for the doctor visit, it paid for the hospitalization, it didn't cover prescription drugs. My dad was a general surgeon. I used to tease him; I said, Well, back then, you only had two drugs, penicillin and cortisone, and they were interchangeable. I know. He didn't think it was funny either. But the prescription drug part of Medicare was an important change that needed to occur, and now we may be reaping the benefit from that.

But it would also be a shame to let this moment -- I appreciate so much your forbearance and your indulgence today -- to let this moment pass without fixing this. The gentlelady from Florida said, Well, last time you put a pay-for on it, it was untenable. Might I remind everybody, it passed the House with that offset. And we can do that again. There are actually more of us now than there were last March, and we can pass it in a partisan vote, if necessary, but how much better would it be if we all sat down and did that very, very difficult, very troublesome, very nettlesome work of providing the offset and made this a meaningful and lasting solution to a very nettlesome problem?

I will accept your observations.

Mr. Lieberman. Well, I say, Amen, really. The other thing I would say, you make a really important point -- and, obviously, not every prescription that everybody gets reimbursed through Part D is exactly necessary -- but overall, to me, it just seems -- and we don't really say this enough and appreciate it enough -- axiomatic, really self-evident that the part of why, generally speaking, we are living longer is because of the positive impact of prescription drugs on the health of the American people, and Part D made those drugs much more accessible to many, many more people, millions more people.

Ms. Rivlin. Yes. Well, I would add my amen too, and the hope, as I have said before, that you seize this opportunity to move ahead and make Medicare -- put it on a track to becoming a more cost-effective program than it is because the pay-fors that have been suggested are not just beneficiary cuts. They really would move in the direction of making Medicare a more efficient program.

Dr. Burgess. I thank my friend from Virginia.

I will yield back.

Mr. Griffith. I yield back.

Mr. Guthrie. [Presiding.] Thank you, gentleman.

Time has expired.

Mr. Collins from New York is recognized.

Mr. Collins. Thank you, Mr. Chairman.

Since I am last, I will be as brief as I can, but as the

junior Member here, in listening to this testimony, it has been an eye-opening discussion where we all agree that we need sustainability and we can't keep kicking the can, as we have done with the SGR doc-fix that, Senator, you called broken and needs to be done away with.

So here is my real question. I think what we are talking about is access. The difficulty of Medicaid is access. The doctors aren't paid much. Therefore, doctors don't see Medicaid patients. The fear of the SGR implementation would be if a 21-percent cut took place, access would be problematic for our seniors. So that is -- the overarching piece is access, and now we are into the details of pay-fors. And I certainly agree with Mr. Shimkus: Let's make sure this is real, and it doesn't add to the deficit and debt that our children are inheriting from us.

So my question really, Dr. Rivlin, would be, when I look at our new program, a half of 1 percent increase for 3 or 4 years, then freezing that for the next 5 years, I am seeing a lot of long-term projections here that are talking about increases; we will fix it now, but then the increases the docs will see half of 1 percent a year, maybe 1 percent a year.

Now, if we are in the inflationary environment we are today, which is all but no inflation, that is one thing, but I am curious, because you have spoken about access before all the way back to 2002 when we first were facing a potential 2 percent cut, what do you think about the new payment plan and the fact that the

increases are very small for the next 10-plus years, and could we be back having this discussion if inflation were to take off in any way? So just curious of your take on that.

Ms. Rivlin. You could be. I don't see inflation as an imminent threat. And long before inflation generally comes back, I think you could get the whole health system on a better track such that almost everybody, and I don't mean just Medicare beneficiaries, was in some kind of integrated health plan that was coordinating their care and giving them as good care as they could get but not wasteful and excessive care.

Mr. Collins. Yeah.

Ms. Rivlin. But I think you can move in that direction and that your -- you have a way to do that with this -- starting with this bill that you have.

Mr. Collins. Thank you.

Senator, do you have any thoughts on that?

Mr. Lieberman. Well, I agree that this is the moment.

Mr. Collins. No. My question was, are we at all at risk, do you think, fixing it now and we would be done with it --

Mr. Lieberman. Right.

Mr. Collins. -- but then the payment schedule set going forth has such small increases --

Mr. Lieberman. Oh, you mean in the current SGR replacement?

Mr. Collins. Yeah. Are we opening the door to a problem down the road?

Mr. Lieberman. It is possible, but I tell you, you have done something so significant that so improves on the status quo, and the repeated crises that called for the doc-fixes and the contortions that that invited here in both Houses of Congress by Members of both parties who took advantage of it and created a mess, really, in the public view, on balance, I don't have any hesitation to say that I think what you have done is worth supporting.

It is not perfect, but, you know, when was the last time any of us did anything perfect? It is an improvement, and that is a -- and it is a bipartisan, bicameral improvement. And, you know, Lord knows, it might just start a cycle of virtue here in accomplishment in Congress that would go on to other areas as well.

The people really need to be given a basis for hope, honestly, and you can begin it right in this subcommittee.

Mr. Collins. Well, I agree.

Your testimony has all been great today, and, you know, I personally want to thank you for staying over an extra half-hour, 45 minutes while we did this.

And thank you, Chairman. I yield back.

Mr. Guthrie. Thank you.

The gentleman yields.

We really do appreciate the panel, it was outstanding, outstanding testimony and very informative, and we do have a lot

of work ahead of us.

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

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

And Members should submit their questions by the close of business on February the 4th, 2015.

And, without objection, the subcommittee will stand in recess until 10:15 tomorrow morning.

Without objection, so ordered.

[Whereupon, at 12:46 p.m., the subcommittee was adjourned.]