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CELEBRATING MEDICARE: STRENGTHENING THE PROGRAM FOR THE NEXT 50 YEARS

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C O N T E N T S

CELEBRATING MEDICARE: STRENGTHENING THE PROGRAM FOR THE NEXT 50 YEARS

FRIDAY, JULY 31, 2015

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 1 p.m., at the Five Star Senior Center, 2832 Arsenal Street, St. Louis, Missouri, Hon. Claire McCaskill, Ranking Member, presiding.

Present: Senator McCaskill.

OPENING STATEMENT OF SENATOR CLAIRE MCCASKILL, RANKING MEMBER

Senator MCCASKILL. The Senate Committee on Aging will come to order. This is a hearing of the United States Senate Special Committee on Aging that we are having here in St. Louis today.

Yesterday was Medicare's 50th birthday, and I think all of us can celebrate that Medicare has given a sense of security and quality health care to seniors in this country since its inception, and I think now it is time for us to look at how we can strengthen the program and make sure we preserve the program for the next 50 years, so that someone 50 years from now can be here saying Medicare just had its 100th birthday.

I want to begin by thanking all of you who have come out today for this hearing. I am so proud to be able to bring another Senate Aging Committee hearing to Missouri. I would like to especially thank my friend and Chairman of this Committee, Susan Collins, who unfortunately could not be here today, but was fully supportive of this hearing and having it in St. Louis. She is a Republican. I am a Democrat, but that does not stop us from working so closely together on a whole lot of issues. I am particularly proud of the bipartisan work that we do together on the Aging Committee.

Let me also thank the witnesses, who I will introduce shortly.

Saving the best for last, let me thank the excellent and gracious staff of the Five Star Senior Center. Mike Howard, the Director, and Laura Haney, the Assistant Director, have been amazing, and I truly appreciate them sharing this wonderful facility with us today.

It is clear that 1965 was one of the most successful years for Congress in modern history. That summer saw the passage of the Older Americans Act, the Voting Rights Act, Medicaid, and Medicare. Upon signing Medicare into law, President Lyndon Johnson

handed the first Medicare card to President Harry Truman, and that occurred right here in Missouri, in Independence.

Medicare really is about Missouri. Only seven months into his Presidency, Harry S. Truman sent a Presidential message to the U.S. Congress proposing a new national health care program. In his message, Truman argued that the Federal Government should play a role in health care, saying the health of American children, like their education, should be recognized as a definite public responsibility.

One of the chief aims of President Truman's plan was to ensure that all communities, regardless of their size or income level, had access to doctors and hospitals. He was particularly concerned with the lack of health professionals and hospitals in many rural or otherwise lower-income areas of United States.

President Truman proposed a national health insurance program that would be open to all Americans. However, when his proposal went to Congress, it was attacked as socialized medicine. Sound familiar? Ultimately, President Truman was not successful in his push for national health insurance, but on July 30, 1965, President Lyndon B. Johnson signed the Medicare bill into law at the Harry S. Truman Library and Museum. He said that it all really started with the man from Independence.

The Medicare program has grown into a beloved part of the American fabric. It is an essential commitment that we as a society have made to Americans in their senior years. Through Medicare, our government provides high-quality medical care to seniors at an affordable cost as long as they need it.

That does not mean that it is without its challenges or threats. There are various proposals being floated to change the Medicare program. Some would make the program better and more efficient. Others would add additional benefits, like dental and vision, but some would completely change the nature of Medicare as we know it, turning it from a guaranteed benefit into a voucher program. I do not support that proposal and have fought hard against it during my time in the Senate.

Let me be clear. The fundamentals of the Medicare program are strong. In 1965, only half of our Nation's seniors were insured. Today, over 98 percent are. Poverty among seniors has been cut by two-thirds since the early 1960's, in part because seniors now have a reliable and secure method of paying for their medical bills, in addition to their Social Security. Medicare helped desegregate hospitals and health facilities. It helps keep the doors of rural and urban hospitals open to serve the needs of all citizens.

The Affordable Care Act, known as Obamacare, made the program even stronger by providing seniors with no-cost annual physicals and preventative care, closing the dreaded prescription drug doughnut hole, and giving us new tools to fight and prevent fraud when criminals try to take advantage of the program, and by the way, the life of the Medicare Trust Fund has been extended by at least twelve years as a result of the Affordable Health Care Act, so Obamacare actually strengthened Medicare. It did not weaken it. That provides not just savings to you, the taxpayer, but also to you, the beneficiary, through lower premiums and co-insurance.

I look forward to hearing from our panel of witnesses as they describe ways to make the Medicare program stronger for the next 50 years.

First, we have Sandra Van Trease. Ms. Van Trease is the Group President of BJC HealthCare here in St. Louis. She provides strategic leadership and direction to the BJC Collaborative LLC, an association of St. Luke's Health System, Kansas City, Missouri; Cox Health, Springfield, Missouri; and BJC HealthCare here in St. Louis; and Memorial Health System in Springfield, Illinois. She is also responsible for overall business and growth strategies for a select group of BJC's community hospitals, including Boone Hospital Center, Missouri Baptist Sullivan Hospital, and Parkland Health Center in Missouri, and the BJC Medical Group, to ensure outstanding clinical quality, operating efficiencies, and financial stability.

In 2012, she was appointed President of BJC HealthCare's Accountable Care Organization and leads BJC's overall efforts in population health. She also serves as a member of the Senior Management Team at BJC HealthCare, one of the largest nonprofit health care organizations in the United States.

She will discuss BJC's experience with and commitment to the ACO model to improve quality and reduce costs for Medicare beneficiaries and taxpayers.

Next is Brit Pim. He is Vice President and General Manager of the Government Programs Division and CEO of the Express Scripts Medicare Prescription Drug Plan. He manages and oversees Express Scripts' Medicare and Medicaid businesses, leadership of the Express Scripts Medicare Prescription Drug Plan, and oversight of the development and implementation of Express Scripts health care reform strategies.

Brit has nearly twenty years of industry, management, and consulting experience. He joined Express Scripts in 2004 and was responsible for leading the company's preparations for the initiation of the Medicare Part D benefit in 2006.

Mr. Pim will discuss how through Medicare Part D Express Scripts is delivering a high-quality, affordable, and meaningful benefit for millions of Americans while reducing costs for Medicare.

Ron Sergent is a former Missouri AARP Executive Council Member and the current Medicare Issue Volunteer Lead for AARP Missouri. He has been a dedicated volunteer, helping health cares understand Medicare and how it was positively impacted by the changes in the Affordable Care Act, known as Obamacare.

Now over 65 himself, Ron is a Medicare beneficiary. He is retired from the Columbia Public Schools, where he taught American government and history. He still lives in Columbia, Missouri.

He will discuss what Medicare means to health cares and how, from a beneficiary's perspective, the program can be improved and strengthened.

Max Richtman is the President and CEO of the National Committee to Preserve Social Security and Medicare. The National Committee is a grassroots advocacy and education organization dedicated to preserving and strengthening safety net programs, including Social Security, Medicare, and Medicaid.

He is very familiar with this Committee, as he is a former Staff Director of this very Committee, the Senate Special Committee on Aging.

He will discuss steps that have already been taken to improve the program and ways to strengthen it in the future with additional benefits, such as hearing, dental, and vision services.

Stuart Guterman is a Senior Scholar in Residence at AcademyHealth, an organization that works to improve health and the performance of the health system by supporting the production and use of evidence to inform policy and practice. Until June, he was Vice President for Medicare and Cost Control at the Commonwealth Fund, leading the Fund's special initiatives on advancing Medicare, supporting the analysis of data and development of policies to improve Medicare as a source of coverage for the aged and disabled Americans. He also analyzes the program as a platform for implementation and testing of new approaches to payment and health care delivery.

His testimony will discuss the opportunity to continue to improve the program and its ability to serve its beneficiaries over the next 50 years.

Thank you all so much for joining us, and with that, why do we not begin with Mr. Guterman.

STATEMENT OF STUART GUTERMAN, SENIOR SCHOLAR IN RESIDENCE, ACADEMYHEALTH, WASHINGTON, D.C.

Mr. GUTERMAN. Thank you, Senator McCaskill, and also thanks to Chairman Collins.

Senator MCCASKILL. Excuse me, can you all hear in the back? You need to get it right——

Mr. GUTERMAN. Right up, okay.

Senator MCCASKILL. Get really close to your mouth, and then it will work.

Mr. GUTERMAN. Okay. How is this? Is this better?

Senator MCCASKILL. Better? Thumbs up in the back? Thumbs up in the back.

Mr. GUTERMAN. Okay. Thank you, Senator McCaskill, and also thanks to Chairman Collins and the members of the Committee, for this invitation to testify on the current State of Medicare and the challenges it faces as it enters its next 50 years.

I am speaking today as an individual who has been working on Medicare issues for a long time, as you mentioned, at the Commonwealth Fund from 2005 until recently, before that, for the last 30 years, actually, at the Centers for Medicare and Medicaid Services and at the Medicare Payment Advisory Commission, among others. I have seen and had the privilege of participating in many of the innovative changes that the program has implemented over the years and also been aware of the challenges faced by the program.

In addition, I have got a mother and stepfather who are both 93 years old and who have been helped tremendously by Medicare's coverage and the access to care it provides, but also hindered by the program's shortcomings and the fragmented nature of health care provided in this country, so I have known Medicare since I was a teenager, I guess, now as it celebrates its 50th birthday.

The program, as you said, has been a tremendous success in accomplishing its main goal, which is assuring the health and economic security of the Nation's elderly and disabled. It is very popular with its beneficiaries and has been influential in shaping the U.S. health system, improving the quality of care, and contributing to medical progress.

At the same time, it faces considerable challenges as it enters its second 50 years. I will talk about some of those challenges and maybe some ways to approach dealing with them as we move on into the coming years.

One, of course, is spending growth. Medicare spending growth per beneficiary has actually slowed dramatically over the last few years, but an increasing number of beneficiaries, projected to increase from about 54 million in 2015 to about 82 million by 2030, has been pushing total spending, and Medicare, although the Affordable Care Act changed the insolvency date for the Medicare Hospital Insurance Trust Fund from 2016 to 2030, still, 2030 can come upon us before we know it.

The question is, is this a problem and how do we deal with it? It is a problem in the sense that the Trustees' Report that came out last week holds up a warning sign. It says, we have still got to work on this program to be able to address its issues, particularly the cost and also the effectiveness with which Medicare spends its money.

We do have to understand one thing, that all of this is coming because we are living longer. That is not a bad thing. Having more elderly people means that people—comes about because people are living longer and that is something we want to see happen.

In addition, I would point out that most of Europe is older than the U.S. is and they have been dealing with this issue for a number of years, but they actually spend much less on health care than we do, so there are things to learn from how others are doing—handling health care and how we spend money on it.

How do we address these issues? Well, the main thing is that we need to make health care more efficient and more effective, and there are policies in place, thanks to Congress and thanks to the folks who work on the Medicare program, that are being tested and developed and implemented, including the ACO program and many other innovations that are being put in place, that are succeeding in slowing health care costs and improving quality of care.

We also have to recognize that if we are going to have more seniors, that means we need to devote a higher proportion of our resources to seniors, and so we need to be able to live with that, as well.

In addition, we need to align incentives better within the program and also throughout the health care system. There has been a disconnect historically, not only between Medicare and the private sector, between Medicare and Medicaid, in fact, and we have to present a set of incentives that the health care system can respond to consistently so that we do not drive doctors crazy and also give a clear message as to what we want from our health care system.

The benefit design of the Medicare program, as you mentioned, can be improved. We have very fragmented coverage. A typical

Medicare beneficiary now gets hospital coverage from Part A, they get doctor coverage from Part B, they get drug coverage from Part D, and then most of them also have supplemental coverage, a Medigap policy or an employer-sponsored policy, and that leads to fragmented health care delivery and it also hinders the coordination of care across settings and between providers, and Medicare beneficiaries would benefit from an improved coordination across all of these programs, so one approach might be to develop a Medicare benefit package that is more coordinated rather than having these differing coverages with different rules and different copays and expenses.

Medicare also has a lack of stop loss protection. Unlike most employer-sponsored care, Medicare beneficiaries are not protected once their out-of-pocket costs hit a certain level, and that is something that has been talked about. It clearly involves figuring out where you want to spend your money, but it is something that would align Medicare better with the private coverage that we all have before we hit 65.

Now, some colleagues of mine and I, when I worked at the Commonwealth Fund, put out a proposal that called Medicare essential, which would, in fact, combine Medicare into one program and also incorporate positive incentives for Medicare beneficiaries who use high-value providers to align the incentives that Medicare is trying to develop for providers and bring that home to beneficiaries, too, so that the two sets of incentives can be consistent and Medicare beneficiaries can be rewarded for seeking care from providers who are doing so in a coordinated way, in addition to having better outcomes.

We also are facing an increasing problem with beneficiaries with complex conditions. Medicare beneficiaries—37 percent of Medicare beneficiaries have four or more complex conditions, and those beneficiaries account for 74 percent of Medicare spending each year, so how do we address that? Well, improving coordination of care helps people get the appropriate care without bouncing around from one setting to another, from one provider to another.

The provision of services that enhance—some of them non-medical—that enhance the Medicare beneficiary's ability to manage his or her conditions without having to go into the hospital or into the doctor and do so on a day-to-day basis, some of this is happening in the private sector, because the case in point, I guess, is taking people with chronic asthma conditions, and people have realized that if you buy them an air conditioner, that helps keep the air quality in their house better and it keeps them from having to go into the emergency room with an asthma attack.

There are many situations like that that Medicare beneficiaries face that could be enhanced by a broader notion of what Medicare can provide. One example of that is the Independence at Home Demonstration that has shown some pretty positive results recently that the Centers for Medicare and Medicaid Services is testing right now, and there have been proposals by Senator Wyden and his colleagues and others to enhance the at-home care that is available to beneficiaries so they do not have to go into the hospital.

A fourth issue that I will raise here is the desire or the need to balance the traditional Medicare program with Medicare Advantage, through which Medicare beneficiaries can obtain their coverage through private plans. Right now, they are really two separate things. Medicare Advantage now has over 30 percent of Medicare beneficiaries, so it is a growing but still a minority of Medicare beneficiaries, and the incentives provided to Medicare Advantage plans versus the incentives provided under traditional Medicare are really inconsistent.

The Congress has been working on that. There were provisions in the Affordable Care Act to do that, to deal with that partially, but we need to keep working on trying to make sure that both the public traditional Medicare program and the private Medicare Advantage programs can bring out the best in what the program has to offer its beneficiaries.

In conclusion, I will say again, Medicare has been very successful in achieving its basic mission, but as the country's largest purchaser of health services, it can do more to improve quality, promote more coordinated care, and control costs, both its own costs and throughout the health care system, because of its unique position, it can be an important testing ground for costs and quality innovations, and policies have already been put in place that encourage such development, but including expanding the power of the Secretary of Health and Human Services to put payment pilot programs on a fast track through the Center for Medicare and Medicaid Innovation created in the Affordable Care Act, and to work with private payers and providers to establish multi-payer initiatives that address these issues.

It is a program that has been extremely successful, popular, and important to its beneficiaries, but it can be improved in several ways, and we have an imperative over the second 50 years of Medicare to continue to work on improving that program. Thanks.

Senator MCCASKILL. Thank you so much.

Mr. Pim.

STATEMENT OF BRIT PIM, GENERAL MANAGER OF FEDERAL PROGRAMS, EXPRESS SCRIPTS, INC., ST. LOUIS, MISSOURI

Mr. PIM. Thank you.

Senator MCCASKILL. You are going to need to pull the microphone over and get close to it.

Mr. PIM. I am. Thank you.

Senator MCCASKILL. There you go.

Mr. PIM. Senator, thank you for the opportunity to share our perspective with you today. As the General Manager of the Government Programs Division for Express Scripts, I am responsible for Medicare, Medicaid, public exchanges, Accountable Care Organizations, and the like.

When I joined the organization almost a little more than a decade ago, the Medicare Modernization Act had just been passed and we were just beginning to prepare for Medicare Part D. Today, it accounts for a growing third of our business. We are happy to serve almost seven million Americans that participate in the Medicare Part D program.

We look at the program and we think it has been phenomenally successful. Seniors have saved money on their prescription drugs, almost $7 billion. Taxpayers have saved money. The program's costs are 45 percent below the original projections, and seniors are happy, largely, with their prescription drug coverage. Ninety-four percent of them report being satisfied, and 95 percent believe the coverage meets their needs.

We believe, in part, the reason why the program has been so successful is because Congress, working with CMS, designed a program that allowed commercial insurance companies to implement and take advantage of common business processes, and one example that I will share with you are preferred networks.

There are more than 60,000 pharmacies in the country. We are able to leverage our size in the business that we represent and negotiate discounts with some of those pharmacies and to provide Medicare beneficiaries with tens of thousands of pharmacies that they can go get their prescriptions filled at, but we recognize tremendous value from that, so today, more than 80 percent of the Medicare beneficiaries are enrolled in a Part D program that has a preferred network.

We think it is innovations like these, practices that have ported from the commercial business into Medicare Part D, that are really one of the reasons why we think the program has been so successful, and for that reason, we think it is important that the non-interference clause that today is in the Medicare Modernization Act be preserved.

I would like to take a couple of minutes and talk about just a few things briefly where we think there are opportunities to improve the program, and I will start first with specialty drugs. To be fair, these are drugs that are being developed to treat conditions where otherwise they might be untreatable, and they are doing some pretty remarkable things.

They are extraordinarily expensive. They can be from $10,000 to $100,000 a year, and in the commercial business, we have the opportunity to control the utilization of those drugs and make sure they are only being used when appropriate, but in Medicare, we do not have the same ability to provide some of those—to enable or implement some of those same controls, so I will give you a brief example.

I mentioned that we support about seven million Medicare beneficiaries. In one of the programs that we support, we had a thousand Hepatitis patients, and for those thousand Hepatitis patients, we spent more than $100 million last year on drugs to treat those patients.

Senator MCCASKILL. For a thousand?

Mr. PIM. For a thousand.

Senator MCCASKILL. And you spent how much?

Mr. PIM. A hundred million dollars. It is fantastic that those patients now have a treatment to cure the disease, but it is not sustainable. I cannot afford to continue to pay those kind of prices and preserve the benefit the way we know it today.

In particular, what I would tell you is that we are not able to make mid-year drug coverage changes in Medicare Part D, so if I am a manufacturer, I have a strong incentive for introducing a

drug in the middle of a plan year, and it almost guarantees that I have 18 months of coverage for that drug, because I am in the middle of a plan year and I have likely already submitted my formulary for the next year and cannot make changes. We would like to encourage CMS to create some flexibility where there are these particularly high-cost drugs where we can make formulary changes where we think it makes sense.

Another example is fraud, waste, and abuse. Prescription drug abuse kills nearly 15,000 Americans and drives 1.2 million emergency room visits a year. In our commercial business, we have invested heavily to develop fraud, waste, and abuse programs. I would like to give you an example of just one patient.

It is a 49-year-old patient who is taking 43 controlled substance prescriptions, from 17 prescribers, from five pharmacies. In just over a year, this person was able to obtain 825 days' worth of drugs. It is a commercial patient, so we were able to pair that person with a nurse case manager. We were able to have that patient go through a rehabilitation program, and now, today, they are seeing one pain management physician. They are getting their prescriptions filled from one pharmacy. We have saved their plan sponsor $40,000, and we believe we have likely saved that patient's life.

We would not be able to implement that program in Medicare Part D and we would like to see CMS allow us to implement those kind of controls in Medicare Part D. We think it would benefit the beneficiaries and it would save the program money.

In closing, as we reflect on the success of Medicare, Express Scripts is looking ahead to the next 50 years. We remain acutely focused on the challenge of high-cost medications and an aging population and the need to continuously innovate. We are proud to be part of an important American legacy and believe our contributions to help keep medicine affordable will help ensure these programs celebrate more milestone anniversaries and are here for our children and grandchildren. Thank you.

Senator MCCASKILL. Thank you very much.

Ms. Van Trease.

STATEMENT OF SANDRA VAN TREASE, GROUP PRESIDENT, BJC HEALTHCARE, ST. LOUIS, MISSOURI

Ms. VAN TREASE. Thank you, Senator. I appreciate the opportunity that you and the Committee have provided me to be here and to speak with you today on behalf of BJC HealthCare. We are——

AUDIENCE MEMBER. You are going to have to talk into the microphone.

Ms. VAN TREASE. How is that? Does that sound better?

AUDIENCE MEMBER. Yes.

Ms. VAN TREASE. Okay.

Senator MCCASKILL. Thank you, sir.

Ms. VAN TREASE. Thank you so much. As I said, I am appreciative of the opportunities to be here before you today, and as you mentioned, my role is as a—I serve as Group President for BJC HealthCare. I also have the honor and distinction to serve as the President of our Accountable Care Organization, which really will

be the focus of my comments today, and we did submit, as requested, the written documentation or the testimony, but I am just going to focus on a few key points in that testimony, if I may.

I would like to share with you, though, just a little bit of background about BJC's Accountable Care Organization. Back in July 2012, BJC was the first health care provider in the St. Louis area, and really one of only 89 across the country at that time, to actually form an Accountable Care Organization and enter into the contract with CMS for the Medicare Shared Savings Program, and our Accountable Care Organization includes ten of the BJC hospitals. It includes our Home Health Division. It includes the three long-term care facilities in BJC, the medical group in BJC, which employs over 260 physicians and over 75 advanced care practitioners, and our ACO, importantly, also includes over 200 independent community physicians.

We serve nearly 40,000 beneficiaries. The majority of those beneficiaries actually are here. They reside in the St. Louis metro area, but we have a substantial portion of these beneficiaries that also reside in more rural communities—Sullivan, Farmington, and in the Columbia, Missouri, area.

The ACO program has really provided us a platform that did not exist before, and it has allowed us to do a couple of things that both of the previous witnesses have mentioned, in part, in their remarks. It is allowing us to focus care in a much different way than we have been able to in the past, and our focus has been around clinical care management, specifically around identifying those patients that have these multiple comorbid conditions, which are very significant.

It has also allowed us the opportunity to focus more directly on what we call transitional care, and that is the care that needs to happen when a patient leaves the hospital and goes to the next setting, be that in a skilled nursing facility or home or other places, but interesting, the third component of our focus that we have found that we have needed is actually—are in other types of support services, services like telehealth, services like medication adherence programs, services like transportation, that heretofore you might not necessarily have encapsulated in the body and the term providing health care.

We in the program, under the Shared Savings Program, we have not yet met the targets established by CMS as it relates to being able to share in the value creation that we have had inside the ACO, but that said, we have successfully bent the total cost of care curve for Medicare, and we have excelled in both the clinical quality and the patient satisfaction performance metrics, and we are very, very proud of that, as well as the feedback we are getting directly from our beneficiaries.

For a moment, I would like to focus on some of our key lessons learned, because we are living this and we are on the journey every day. What we have found is that we must focus on identifying and then reducing clinical care variation that is not necessary. That means gaining efficiencies in workflow, in the physicians' offices, in all of our care settings. I wanted to give a couple of examples of what we are talking about.

As a result of this work we have done over the last couple of years, we decided to establish what we are calling a patient access. It is a centralized patient access center. This, among other things, opens things like phone lines for patients and their families to really gain access when they are seeking appointments with a variety of their caregivers, or, frankly, they just need someone to answer some questions, and we believe by opening up this access center, we are avoiding unnecessary emergency room visits and our beneficiaries are able to access their physicians or their primary care health provider in a way and on a timely basis that had been a little bit more difficult for them in the past. We have extended physician office hours. We focused our physicians on blocking out enough time annually, at least once a year, for our doctors to sit down with the beneficiary and conduct a very comprehensive care plan on their behalf.

Other things we have learned that we needed to do, clinical data integration and aggregation has been extremely important so that we can provide actionable information to our caregivers for their patients, so reorganizing technology infrastructure and the data sets that we do now get from our own electronic data sources as well as what CMS provides us, we are now able to provide more information in a seamless way in patient charts, for physician notes.

We are using data experts to actually help us identify patients that our clinicians would deem at high risk, and importantly, also those patients that are deemed to be rising risk, and we have to do that systematically, because if we do not do that on a systematic basis, we cannot scale our efforts and make sure that we get interventional care delivered on the most timely basis to prevent something negative happening to one of our beneficiaries.

Care manager dedication, so clinical care managers has also been something we have had to invest in, to focus and help our physicians and their offices focus on these high and rising risks, so we are embedding care managers in local physician offices or in their geographies to actually provide additional support, not only to the doctors and the office staff, but also to the patients and their families as they are working on access issues, getting appointments, medication adherence, and, again, even basic things like transportation.

I wanted to give an anecdote to you as an example of impact in the real world, the life of one of our beneficiaries. In April of this year, one of our patients—I am going to call her Mrs. Green, that is not her real name—Mrs. Green was admitted to the hospital for a very serious GI issue, and she then had a multitude of other issues that quickly manifested, including renal failure, and for the next three months, so April and May and a good part of—well, it actually started in March, April and May—she spent a total of 38 days in the hospital and ten in rehab.

This team of ours worked with her and her physician, and we learned things that were exacerbating Mrs. Green's situation and was putting her at very high risk for readmission into the hospital. Something very basic as the fact that her physician's office was a fair distance away from her home. Mrs. Green had virtually no reli-

able means of transportation, and she had virtually no family support.

Between the care manager and our staff social worker, we worked with her and her physician to educate Mrs. Green about early warning signs if something in her health started to deteriorate, and most importantly, what to do about that in her home and how she should take care of it and what she should do.

By virtue of spending that kind of quality time with Mrs. Green, I am very happy to let you know she is doing quite well at home. She has not had an ED visit. She has not been back in the hospital, and what we learned here is that this delivery of health care is now encompassing a body of work that before we did not really have the programmatic infrastructure to execute on.

We have had a lot of successes, and there are many to name, but I wanted to share with you, notwithstanding that progress, I wanted to share a few challenges, as well.

Some of my colleagues and I actually had an opportunity to visit with some of the CMS leadership earlier this year, and we shared with them some of the challenges and some of the observations that we had in order to help make the program better under the—the ACO program better. I thought I would share a few of those with you today.

One is around something called the homebound status. Now, currently, Medicare requires patients to qualify for this homebound status in order for the clinicians to receive reimbursement for their services, and that is when the home health nurse goes out to visit, and there are criteria that must be established, but the way the regulations are currently written, it creates a bit of an arduous process for the physician and, frankly, for the patient, because the assessment has to be done only by the physician and it has to be done face to face, and given many of our seniors are dealing with things like this transportation issue, we would and have requested that CMS take another look at those regulations to see if we cannot streamline them to make sure that we are getting the right care at the right time by the right person available in this particular situation and help streamline that care coordination.

Another area of focus that we have shared with CMS revolves around the very real and increasing opportunities provided by telehealth. Telehealth offers a lot of benefits, a lot of potential benefits to our seniors. That includes increasing the access to specialists. Again, this is a transportation issue, but because of the way the rules are written today, there is minimal reimbursement for telehealth services, and when you are dealing with a lot of folks in rural communities, that can be particularly difficult.

Again, we would ask that CMS consider taking a look at providing waivers to certain restrictions that allow us to recognize and then benefit from the developing opportunities in telehealth.

Last, I do want to applaud CMS for actually approving a waiver related to a rule that is called the 3-day inpatient rule. This allows us to coordinate directly with skilled nursing facilities in a way, again, we had not been able to do that before. The regulations came out. We are going to be able to get the waiver. Unfortunately, we do not get the waiver until January 2017, so we will have a little bit of a time lag, about a year and a half or so, before we are

able to take benefit of that, but really, to summarize, you know, in participating with this ACO over the last three and a half, three years, soon to be three and a half years, when we are successful, what we believe, when we are successful in this ACO, our patients will, in fact, experience better health. Our communities will have better health care, and we will provide even better value, and that is about achieving the triple aim.

I wanted to thank you and the Committee for the opportunity to be here today. On behalf of BJC HealthCare, we are very privileged and proud to be able to participate in this event today commemorating the 50th anniversary of Medicare, and for the next 50 years, we will strive to be a leading partner with Medicare as we continue to evolve new innovative programs to serve our seniors.

Thank you very much.

Senator MCCASKILL. Thank you.

Mr. Richtman.

STATEMENT OF MAX RICHTMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE, WASHINGTON, D.C.

Mr. RICHTMAN. Thank you, Senator McCaskill, for inviting me to testify here today. As a former Staff Director of the Senate Special Committee on Aging, I am very proud to have been part of that Committee's long history of highlighting the needs of the aging community, and I commend you, Senator, for continuing that tradition in your service on the Committee and as the Ranking Member.

Also, thank you, Senator, for co-hosting the party last night at the Kennedy Caucus Room celebrating the 50th anniversary. We had a beautiful cake. I am Chairman—besides being the head of the National Committee to Preserve Social Security and Medicare, I chair the Leadership Council of Aging Organizations, 72 groups that work together regularly, and they were all there, and they all want to thank you for the terrific food and beverages. Thank you very much.

I am testifying today to share the National Committee's views on how to strengthen and improve Medicare for the next 50 years. Before Medicare, as you said in your opening statement, half of seniors did not have health insurance, and 35 percent lived in poverty, and today, more than 55 million Americans receive guaranteed health care benefits through Medicare, regardless of preexisting conditions, regardless of income.

Together with Social Security and Medicaid, Medicare forms the bedrock of economic health security for seniors and people with disabilities. As I mentioned last night, these are great programs, Medicare, Medicaid, and Social Security, but they are beyond programs at this point. They are really values, American values, part of our fabric of America.

While Medicare has been a blessing, the current and future needs of seniors demand that the program's coverage become more comprehensive. Today, in addition to premiums, deductibles, co-insurance, many seniors have to pay out of pocket for gaps in Medicare coverage.

The financial burden of these coverage gaps will only grow over time as retirement savings and income continue to shrink. We have

seen that happen for quite a few years now. Seniors have less income in retirement because employers have scaled back or eliminated defined benefit pensions. The loss of retirement benefits is even worse, as you know, for communities of color, because those folks have the highest poverty rates and have the least amount of wealth.

In addition, stagnant wages are grinding away at the middle class's ability to save for retirement. In other words, you cannot save what you do not earn. What little disposable income middle-class Americans have is often used to take care of children, grandchildren, aging parents, and so forth, and that is why millions of Americans reach retirement age without enough private savings to live on.

That is why 40 percent of Social Security beneficiaries depend on Social Security for 90 percent of their income in retirement, and that is why Medicare households, even with Medicare, spend three times more than the average household on out-of-pocket health care costs, and as a result, any future for Medicare must, we feel, must fill these coverage gaps that will become increasingly unaffordable.

Making Medicare coverage more comprehensive is not without precedent. It is a dynamic program. All of these programs are dynamic and have changed over time, for the most part, in better ways.

In 1972, Medicare added coverage for individuals with disabilities and end-stage renal disease. In 1982, Medicare added coverage for hospice care, and as we all know, a prescription drug benefit was added in 2003, and mental health benefits were significantly improved in 2008.

As you pointed out, the Affordable Care Act, despite all of those awful ads that we saw in many election cycles about Medicare cutting, cutting, cutting—or, the Affordable Care Act cutting Medicare by $767 billion—I know this is polite company here, but those were lies. Medicare—there were savings of $716 billion in the Medicare program. Most of those savings went to improve the program. For the first time ever, Medicare under the Affordable Care Act provides a lot of preventative care—colonoscopies, mammograms, diabetes screening, that awful doughnut hole that you talked about is going to be eliminated completely. It is being reduced and will be eliminated completely in a couple more years.

Again, as you noted, the solvency of the Medicare program, the Affordable Care Act added 13 years to the solvency of the program, and the Trustees just told us a few weeks ago it is now solvent until the year 2030.

The National Committee strongly believes Congress should equip Medicare for the economic and health challenges facing seniors in the 21st century. I am talking about creating a catastrophic out-of-pocket limit, which we advocate. We talked about the hospital observation status. I do not think we can wait until 2017. There is legislation in the Congress that would count those three days toward the availability of skilled nursing care. A lot of people leave the hospital and all of a sudden face enormous bills, and that is not right, and vision, dental, hearing. You know how important those are to everybody, but particularly to seniors.

Last week, I participated in a press conference in the U.S. Capitol to promote your colleague, Congressman Debbie Dingell's bill to expand Medicare to include hearing testing and hearing aids, and that legislation, I hope, will get some momentum this year. It recognizes that hearing loss goes untreated because many older Americans cannot afford to pay for hearing aids, and if seniors cannot hear, they get confused, embarrassed, frustrated, withdraw from normal activities.

We had—you will find this interesting, I think. We had at the press conference a highly regarded doctor at Johns Hopkins, a researcher named Franklin Lynn and he has developed some groundbreaking research that draws a connection between hearing loss and dementia, not just the isolation part, but changes in the brain that have an impact on dementia and Alzheimer's, so we are going to be pushing hard to try to get Congressman Dingell's bill passed into law, and I think it is important that we get out that information about the link to dementia.

In closing, again, thank you for inviting me. Seniors understand Medicare is vital to living in dignity throughout their retirement years. They understand Medicare, as I said, is not just a Federal program, it is an American value, and the dream, the American dream of livable retirement is being threatened by the economic realities the middle class faces. We have had enough of proposals to cut benefits, raise the age, privatize the program, and we are going to spend the next couple of years trying to improve the program, and this 50th anniversary, I think, is a good point to begin working to expand those coverages and make them more comprehensive.

Finally, I do not want to embarrass you, but we have a scorecard, like other groups have, and I want to thank you for your consistent votes on behalf of seniors. We have 47,191—I checked this morning—members and supporters in the State of Missouri, and they ought to know that in the last Congress, you had—you can have a score of zero, you can have a score of 100. You had 100. In the Congress before that, you had 100 percent, so as far as we are concerned, you are voting the right way day in and day out, and I thank you for that.

Senator MCCASKILL. Thank you very much, Mr. Richtman. I wish I had 100 on everything.

Mr. RICHTMAN. So do I.

Senator MCCASKILL. Mr. Sergent. We need to move the microphone. Thank you.

STATEMENT OF RON SERGENT, FORMER AARP EXECUTIVE COUNCIL MEMBER, AND MEDICARE ISSUE VOLUNTEER LEAD, AARP MISSOURI, COLUMBIA, MISSOURI

Mr. SERGENT. Thank you, Senator McCaskill, for including AARP and myself in this hearing. We consider it a real privilege, and I am happy to represent the approximately 750,000 members of AARP from Missouri. About 45 percent of those are Medicare eligible, I being but one of those, so——

Senator MCCASKILL. You need to get right up on the microphone. They are having trouble hearing you. It almost feels like it is too close if you are close enough.

Mr. SERGENT. As I was saying, I am happy to represent the almost 750,000 members of AARP in Missouri. About 40 to 45 per-

cent of those are Medicare-eligible, and, of course, those under 65 will at some point become eligible.

I am a volunteer. I have great respect for the professionals to my right. I hope to talk to you just a bit as a beneficiary on behalf of the beneficiaries.

As we commemorate Medicare's 50th anniversary, it is essential that we not only celebrate what it has meant to so many people, but we must also be honest about what Medicare means today, what it covers and what it does not cover, as we have heard. We must recommit ourselves to keep this vital lifeline strong for current and future generations.

From the beginning, AARP's founder, Dr. Ethel Percy Andrus, supported the creation of a Federal health insurance program for all older Americans tied to Social Security. The essence later became, as we know, Medicare.

As we have already heard, back in 1965, three out of four Americans under the age of 65 had adequate private hospital insurance, but according to AARP's research, only one in four—not half, but only one in four over age 65 were as fortunate. If you were an older person, getting sick meant you risked not only losing your health, but your financial independence.

Today, 50 years later, Medicare provides guaranteed affordable coverage for roughly 45 million Americans 65 and older and about nine million people with disabilities. Medicare is largely responsible for the poverty rate among older Americans dropping to less than one of every ten.

Just anecdotally, I would like to share with you, after friends learned that I was going to be here to testify, one of them mentioned that last year, she and her husband had $27,000 out-of-pocket expenses, and without Medicare, they would have been bankrupt.

The program has transformed the lives of millions by helping them to pay for many vital health care services, including hospitalizations and physician visits and prescription drugs, and, has been mentioned more than once, most recently, essential preventative services have been added to Medicare by the Affordable Care Act, and as a volunteer in charge of educating seniors about the Affordable Care Act, I have found that that is a very glaring omission in information that seniors have. I think we really need to do a better job of educating them about what is available to them under the Act.

I would also like to point out to my friend that too many seniors look at the Affordable Care Act in a negative fashion. It is hard for me to understand, but I try my best to educate them. I think most of it has to do with lack of knowledge.

While Medicare offers important benefits, Medicare is not a free ride. It is not a Cadillac plan, more like maybe a reliable Chevy. There are premiums, deductibles, copays which people have to pay, and there is a lot that Medicare simply does not cover. I speak to you now as a beneficiary. It does not cover the cost of dental, vision, or hearing problems. Myself, I have a hearing loss and I have spent over $15,000 on hearing aids over the last 12 years. The need for eyeglasses and hearing aids is particularly common among

older people. Moreover, Medicare does not cover long-term nursing care and home care.

It is important to remember that half of all Medicare beneficiaries live on incomes of less than $23,500 a year. The average out-of-pocket cost for beneficiaries and for cost sharing of services is about $4,500. For the typical beneficiary, this represents over 17 percent of their income. Some of those numbers may not seem so great to those of us who are still earning a reasonable income, but when you consider 17 percent of your income goes to out-of-pocket expenses, that is a significant amount.

Medicare's golden anniversary is a time to think ahead about how we can ensure that the program continues to fulfill its essential role. Medicare today faces a number of challenges, including the rising cost of health care and a growing aging population. Some say the answer to these challenges is simply to cut benefits or force seniors to pay more.

AARP believes that there is a better way than that. We think there are responsible solutions that can and will stabilize the system, and we have heard some of them today. We can start to put Medicare on a stable ground by clamping down on drug companies' high prices, improving coordination of care, using technology to make care more accessible and efficient.

Looking forward, we must recognize that the way people receive care is changing. For instance, more people are receiving care from non-physician providers and are using telemedicine to access care more conveniently.

Additionally, I do not know that we have had this addressed yet—we find that almost nine in ten seniors say they want to remain in their home as they age. We should do everything we can to let that happen. Aging in place helps maintain a better quality of life and is less costly than institutional settings. This means funding community-based services, such as Meals on Wheels, which help older Americans live independently. It also means supporting family caregivers through better tax policies and workplace programs which recognize the economic contribution made by individuals who take care of loved ones.

AARP stands ready to help keep Medicare strong for the next 50 years, and I thank you very much for the invitation.

Senator MCCASKILL. Thank you so much.

Let me start with the Accountable Care Organizations with Ms. Van Trease, and let me just explain, so everyone understands. The idea here—we use the letters ACO. The idea is a simple idea. The idea is that—let me use my mother as an example.

Near the end of her life, she was an insulin-dependent diabetic. She had serious arthritis. She had a heart condition and a pacemaker, so she had a number of chronic problems, and this—she is not an unusual American near the end of their lives. She was seeing a different doctor for each one, and I could not get her to say to the doctor, "I am not going to draw a blood sample for you because I drew one for the doctor yesterday. Use his." Each one of those doctors was replicating some of the work that the other doctors needed and there was no sharing.

As a result, the costs to Medicare were much more expensive and, frankly, I was the one that was trying to ride roughshod over

the list of prescriptions because the doctors were not doing a good job—so, this brings you in, Mr. Pim, too—because the doctors were not doing a good job of really checking to make sure that all of her prescriptions made sense together.

The idea behind an Accountable Care Organization was that there would be a primary doctor that would be like a gatekeeper or the sheriff that would be paying attention to what everyone else is doing, and with that, a team of providers that would be giving the level of care that was needed, but not more.

Instead of my mom going to the emergency room, what she really needed, perhaps, was to have her blood sugar checked by telemedicine, or maybe she needed a home visit, and that is what the ACO is about, so with that in mind on the ACO, I am curious if we are incentivizing enough on Accountable Care Organizations, and by that I mean when my mom had a nurse—we hired a nurse to come to the house and see her. We were blessed that we could afford that, and this nurse knew that we were looking to keep Mom out of the hospital. Mom did not want to go to the hospital. Mom was not happy in the hospital. Mom did not get better in the hospital, so we wanted to keep her home. This nurse knew her goal was to keep Mom at home and she worked really hard at it, because she knew if she did, she was going to get compensated more—not that she did not want to anyway, because she cared. She was a good nurse, but are we experimenting enough with incentivizing that? I think the fear about home health care is runaway costs. Could we not combine home health care with, you are not going to get paid a lot of money unless you are successful at what your goal is, which is, overall, bringing down the number of incidents that require emergency room or hospitalization?

Ms. VAN TREASE. Yes. A lot of components to that question, Senator. Yes. I think that one of the things that we are doing and others are doing is, in fact, within the structure of the Accountable Care Organization, because we have certain waiver protections. We, from BJC's standpoint as a primarily acute-based organization with our medical group and our affiliated physicians, we can now work together in ways that, legally, we could not work together before.

That allows us to explore different ways to create incentives as we do things, not only within the construct of something known as the patient-centered medical home, which we are, and that puts that primary care physician, whoever he or she might be, fully in charge of the team and really leveraging their expertise across care managers, social workers, pharmacists, other health coaches, dietary, behavioral health. We create a team and that team has its own set of goals and objectives to work together in a way that, again, they had not been able to do that before.

As we focus on this, there continues to be a clear need to continue alignment, economic alignment as well as just people who are good professionals who want to take the best possible care of patients.

Having these constructs like the ACO, having constructs that are coming out of CMMI, the innovation division of CMS, bundled payment concepts, these are all experiments that try to tie all of this together so that we get out of our silos from a health care perspec-

tive and look at the totality of the entire person across his or her multiple conditions, not individual conditions. I think you are exactly right that there are some continuing opportunities in that area.

Senator MCCASKILL. How close are you from—you said that you are bending the cost curve——

Ms. VAN TREASE. Yes.

Senator MCCASKILL [continuing]. but at a certain point, the idea is you do this so well, you get compensated more for it——

Ms. VAN TREASE. That——

Senator MCCASKILL [continuing]. kind of like my nurse example.

Ms. VAN TREASE. That would be—yes——

Senator MCCASKILL. How close are you to actually getting more compensation for having succeeded in bringing down costs?

Ms. VAN TREASE. In our first contract year, the first contract year that it was in existence, we were, as a participant in the Medicare Shared Savings Program, Medicare sets a corridor around some of the economics, and so what we have seen over the quarters that we have been doing this-—and we have been in it for three years now—we have seen a nice steady decline in the trend line, the health care cost trend line. We are bending it downward.

That is really great news as a taxpayer and as Medicare, because that means we have lowered the total cost of care——

Senator MCCASKILL. Right.

Ms. VAN TREASE.—and, simultaneously, actually improved our quality scores and our patient satisfaction scores, but we have not gotten outside what Medicare has set as the savings corridor, so right now, all of this is on BJC P&L, so we really have not received any of that compensation.

Senator MCCASKILL. Do you think you are going to get there?

Ms. VAN TREASE. We are working aggressively to get there. It is our intention, and to do that, then, when we are successful, allows us the flexibility to share in some of that with our physicians and our other caregiver partners, and that is an objective we have, as well.

Senator MCCASKILL. How quickly are the lessons that you have learned being adopted systemwide?

Ms. VAN TREASE. Yes——

Senator MCCASKILL. What I worry about is we have done these wonderful little oasis of sanity in terms of how we are delivering health care, which I think is what the ACOs represent——

Ms. VAN TREASE. Right.

Senator MCCASKILL [continuing]. but it is still the exception and not the rule. What steps do you think are being taken to make sure that what you are learning about Mrs. Green and what you are learning about the other patients in terms of this system—how is CMS doing? What do I need to do to crack the whip at CMS about adopting these lessons systemwide?

Ms. VAN TREASE. Mm-hmm. Well, I think from a CMS perspective, the great news, I do think, is that they are listening to these concerns and they are inviting organizations like ours, large Accountable Care Organizations that take care of significant population, to explore ways to make things better. Some of this is about dealing with waivers and regulations and the restrictions that are

in the testimony. That is probably the fastest thing that they can do.

There is a lot of behavioral change across our systems. We have trained our patients well to go to the ED as opposed to go to their primary care physician. We have trained them well that perhaps they do not need a primary care physician, so there is a lot of behavioral change——

Senator MCCASKILL. Yes.

Ms. VAN TREASE.—that has to happen on the part of beneficiaries. It has to happen on the part of physicians, because we are asking them perhaps to practice in ways that they did not train for and to develop skill sets in other ways, so part of this is going to be progression, evidence of success, celebrating success, communicating what works and what does not, alignment of the economics, and then providing health care organizations like ours with the capability legally to do the things that we are now after, with the right kind of protections, obviously, around things that we do not want to run amok, clearly.

Senator MCCASKILL. I learned something today, Mr. Pim, about—I have learned a lot from all of you, but one of the things that struck me with your testimony, speaking of regulations, was the notion that when you see 825 days' worth of pain medication in one year to one patient, you have the ability outside of Medicare to take steps, as somebody who is filling these prescriptions, but you cannot do that with Medicare.

Mr. PIM. That is true. I think it is an unintended consequence of the regulation, to be fair, but it——

Senator MCCASKILL. That is what I specialize in fixing——

Mr. PIM. Yes——

Senator MCCASKILL [continuing]. is stupid regulations.

Mr. PIM. And that is——

Senator MCCASKILL. That is my job, is to fix a stupid regulation.

Mr. PIM. That is where we would like help, the details of which we put in our written testimony.

Senator MCCASKILL. Right now, if you see—and, by the way, just so everyone understands, one of the biggest health threats in the Midwest right now is heroin, and that is a direct consequence of opioids being prescribed. When I was growing up, you did not get Vicodin when you went to the dentist. You certainly did not get 30 of them, and there is so much pain medicine being prescribed that kids are getting a hold of it, they are getting addicted, and then heroin is cheaper and not regulated, so they are taking amounts that are deadly.

Mr. PIM. Absolutely.

Senator MCCASKILL. We are now losing more young people to heroin addiction than we are to car crashes, and that is a serious problem, not just in Missouri, but throughout the country, and by the way, a lot of that medicine starts sometimes by grandmother having the medication, or aunt having the medication, not that it was prescribed for the young person, but in my own household, I saw opioids stolen from my mother by family members who were up to no good.

Is the regulation because they do not want pharmacies to see what—what is the rationale behind the regulation that you cannot reach out and stop this kind of abuse in the Medicare population?

Mr. PIM. The regulation prevents us from restricting who can write a prescription for that patient and restricts our ability from putting some constraints around what pharmacies that patient can go to.

We are not trying—in the commercial setting, what we say is, similar to the ACOs, we want a provider, a single provider, to coordinate your care and make sure that you are not taking competing therapies or more than you should, and that is done best if one person is responsible for your care, and it is done best if you are getting that care from one setting, ideally. The Medicare requirements today do not allow us to put those kinds of restrictions around a beneficiary.

Senator MCCASKILL. Are there conversations ongoing with CMS now——

Mr. PIM. We have been trying——

Senator MCCASKILL [continuing]. about those restrictions?

Mr. PIM. We have been talking to CMS about it, but we would like to see more progress more quickly.

Senator MCCASKILL. This is for any of you to speak up, and maybe, Mr. Sergent, you could talk about this. I think one of the things that was most—there were a lot of things that were upsetting about the Affordable Care Act, and one of them is what you said, Mr. Sergent. There is a lot of misunderstanding about what it did and what it did not do.

One of the things that I was so depressed about was the whole death panel controversy, and maybe one of you have the number. What percentage of the Medicare payments go out for the last 30 days of someone's life? Does anybody know off the top of their head?

Mr. SERGENT. Well, I will defer to the experts. I have a number that has been repeated to me, that something like 40 percent of the total cost of Medicare is in the last five years.

Senator MCCASKILL. Forty percent of all the costs of Medicare come in the last six months of someone's life, and so what we—what was an amendment to the health care bill in the Committee by Republican Chuck Grassley from Iowa was the idea that we would reimburse Medicare doctors for the time they took to talk to their patients about end-of-life nutrition and hydration.

I know—once again, I will call on my mother. She is in heaven, watching, smiling. She is so glad all of you are here, by the way. She thinks you should all come out and see your elected officials.

My mother was adamant with us about what she wanted at the end of her life. It was very clear to us. She had it in writing. She would yell at us about it at least once a month. Now, this is what I want at the end of my life, so when the time came, we knew when it was time to take Mom out of the hospital and bring her home, get hospice, and my mother died in my living room with all of us around her, laughing, smiling, and that is what she wanted. She did not want more at the hospital. She wanted less when that time came.

It was easy for us, because we had clear instructions, but most families do not have that, and so at the end of life, they do not know what mom or dad really wants, and if they do not know what mom or dad really wants, they are in the most emotional and conflicted place they will ever be in their life, because your emotion is, I want to hold on to mom. I want to hold on to dad.

I had an ICU doctor at your hospital tell me that someone was kept on a machine, was brain dead, had no valuable life left, because the family wanted to wait until the son graduated from college in a month to come say goodbye. That is an incredibly expensive month. I understand you want to hold on for a month, but that is one of many examples that ICU doctors can talk about in terms of end of life.

Let me ask you, Mr. Sergent, what can we do about getting Medicare beneficiaries to understand about directives for their end-of-life, and I believe there has now been a rule—am I correct about this—that doctors can begin to be reimbursed for this?

PANEL MEMBER. Yes. Yes.

PANEL MEMBER. This just happened a couple of weeks ago.

Mr. SERGENT. I do not know exactly where to start with that answer. I am so frustrated by that complication. I talk to a lot of seniors in the role that I serve, and there has been so much noise, so much false news about that particular conversation, that one of the things that I have discovered is that when seniors have made up their mind about death panel discussions, you cannot get them to see—it is almost like a cognitive dissonance.

You cannot get them to understand that that is, number one, not true, never was true, could not possibly be true, in my opinion; and number two, the opposite is true, that you get a good conversation designed to inform you and your primary care physician what your hopes and intentions would be.

That does not mean that you have to be on the verge or edge of death. This should be a conversation—I have already had this conversation with my physician, who I think is a remarkable man. We also have it in writing, but my point is, you do not have to have that at the end-of-life conversation.

I wish I could tell you that there was something that I could suggest, that if you could support, we could get it done. All I can tell you is that I wish proponents of what is so good in the Act were more willing to speak out, because as you very well know in your position, sometimes when you speak out against this noise or false news, if you know where I am going with that, it can result in a vicious counterattack.

Senator MCCASKILL. Yes. Mr. Guterman.

Mr. GUTERMAN. Senator, I wanted to add that the whole issue of palliative care and the kinds of services that can help people at the end of life is not just an end-of-life issue and is not just the cost issue. I mean, the fact is that a lot of costs in Medicare are concentrated at the end of life because many of these people are sick. It is not surprising that people are very sick——

Senator MCCASKILL. Of course.

Mr. GUTERMAN [continuing]. right, in the last year of life.

Senator MCCASKILL. Of course.

Mr. GUTERMAN. What is more important is not the decision about when to pull the plug but providing services that help people live a reasonable life at the end of their life, to help provide them with services to make them comfortable and not plug them into machines and pump them full of drugs to try to, you know, squeeze every last moment out of that duration of life.

The quality of life is really important, and it is really, if we look at it as a quality of care issue, you know, rather than just a cost issue or a pulling the plug issue, I think people would be able to really reconcile themselves to this thought, that, you know, you are not going to live forever. Grandpa Joe is not going to live forever, and plugging them into machines actually ends their life prematurely because it sours the end of that whole lifelong experience.

Senator MCCASKILL. I think you are exactly right. I mean, what you are saying is what we ought to be focused on is a quality of life, and how can we form the Medicare program so that you get the most quality out of life for the longest period of time, but then, hopefully, have decisions made at the end.

Ms. VAN TREASE. Senator, I might just—might build on that thought, because the data also tell us that, appropriately used, palliative care in pre-hospice actually extends a person's life, and I think palliative care and hospice care are significantly——

Senator MCCASKILL. Why do you not define palliative care for everyone.

Ms. VAN TREASE. Palliative care is really—think of it as comfort. You are making someone comfortable. It is not intended for curative. It is unlikely the person will recover, and it is comfort in nature, so that the quality of a person's life is at the highest level is possibly can be. They are not in pain and they are not confused about what is happening, and we under-utilize both that and hospice care.

Unfortunately, many people—hospice care is actually the transition between life and death care, but many people are not able to take advantage, perhaps because they are not having these crucial conversations with their physicians and their families, and hospice care, oftentimes, people are only in hospice for a few days. That is probably under-utilizing hospice. They are staying in the ICU, which is probably not where most people would like to spend——

Senator MCCASKILL. Right.

Ms. VAN TREASE.—most of their last days.

Senator MCCASKILL. Right.

Ms. VAN TREASE. I do think those kinds of things that continue to educate and appropriately compensate the physicians to have these very significant conversations with the patients are going to be beneficial in the long run.

Senator MCCASKILL. Which is more expensive, a R.N. going to someone's home or someone coming to the ER?

Ms. VAN TREASE. The ER.

Senator MCCASKILL. I am trying to figure out—we have done all of this regulation around whether or not you can get home care, but we have no regulation about whether or not you can come to the ER, right?

Ms. VAN TREASE. That is correct.

Senator MCCASKILL. So, you know——

Ms. VAN TREASE. In fact, we do have regulation, which says anyone must be seen.

Senator MCCASKILL. Right. What we are saying is we have got to make sure that you really deserve a nurse at home, but we do not need to make sure you can walk in any ER in America, insured, not insured, under-insured, and we are required to give you medical care. That seems backward to me, I mean, not that we want to ever have anybody have to qualify for the emergency room——

Ms. VAN TREASE. Right.

Senator MCCASKILL. The point I am trying to make is it seems backwards that we are doing so much regulation around the ability to get home care. Where did that come from?

Ms. VAN TREASE. Well, again, I think most regulations come with good intentions, and sometimes they just have negative consequences, particularly as we think about the new models of care that we need in order to protect the solvency and increase high-quality care.

I do not know—I could not answer exactly where the origins are. I think, though, the point is we are recognizing that there are these barriers. There is going to continue to be a challenge in providing enough doctors in order for the growing number, the 10,000 Medicare beneficiaries coming on a day are going to need more and more care, not less, as we all age, and let us keep in mind that we have a whole lot of doctors that are falling into the retirement age, as well.

We need different types of models that allow nurses to work at the top of their license. That can be home care nurses, it can be care managers who facilitate the physicians' office work, but our regulations are set up for the old way and we need to identify which ones specifically. Either get waivers quickly and then rewrite the regulations to facilitate.

Senator MCCASKILL. Do we not have a critical shortage of gerontologists?

Ms. VAN TREASE. We do, indeed.

Senator MCCASKILL. Is that because they are not making as much money as other kinds of doctors?

Ms. VAN TREASE. Well, you know, I think economics play into a physician's decision as to what to do with his or her skill set. The fact of the matter also is, though, again, we are aging faster than we are producing doctors with, frankly, any of the specialized skills, so this is just going to be a fundamental challenge for us, which is, again, why we are advocating with our physicians learning better ways to do team-based care so that certain things that a doctor might have historically done which could be done through licensing of pharmacists, advanced care practitioners, paramedics, nurse practitioners, we need to distribute the care model.

Senator MCCASKILL. Yes, Mr. Guterman.

Mr. GUTERMAN. Also, I would add—let me point out that the solution to this is not more regulation, but actually less regulation and more—I mean, the restriction on home health comes from the fact that Medicare was originally designed as an acute care program and it was designed under a fee-for-service system, so people get paid more for doing more, and in a system like that, if you open

up more services and if you do not regulate them, you are going to end up with people abusing the use of those extra services.

If you align payment, instead of rewarding people more for doing more and doing more complex things, to rewarding people for getting better outcomes and providing better care to their patients and providing better patient satisfaction, better patient experiences from that care, then you can expand the services that you can allow people to do, because then they are doing those things from a broader perspective.

That is true for drug coverage, too. I mean, rather than, you know, giving the drug plans the power to restrict what individual beneficiaries can use, there is a medication therapy management provision in the Part D law, and if you plug—and it is an artifact of—this disconnect is an artifact between—of different Part A, Part B, Part D coverage, and so people do not have any opportunity and certainly no incentive to talk to each other to help manage the patient more broadly, and then a lot of these problems can be eliminated.

Senator MCCASKILL. That goes to your point you made in your testimony, that if we kind of blurred the lines between A, B, and D and had this be a more holistic program as opposed to the silos of A, B, and D, it would make a lot more sense, which—and that brings into play the 3-day observation, because it is the separation of those three that end up having these anomalies in classification, whether it is observation or treatment, because it has direct impact on whether you get reimbursed, because if you are not admitted into the hospital, you do not get A and it goes to B, right?

Ms. VAN TREASE. Right.

Mr. GUTERMAN. Absolutely.

Senator MCCASKILL. I am getting my alphabet right, am I not?

PANEL MEMBER. It is not just that you do not get reimbursed, you may not even get the care. You may not be able to get the care in a skilled nursing facility——

Senator MCCASKILL. Then you cannot go to a nursing home.

PANEL MEMBER. That is right.

Senator MCCASKILL. Because you have not been admitted.

PANEL MEMBER. Yes.

Senator MCCASKILL. Because under the rules, you cannot go to a nursing home if you have not been admitted to a hospital, so——

PANEL MEMBER. For three days.

Senator MCCASKILL. For three days. If you are in for observation, which sometimes—which is, you know, I mean, we have put all these artificial regulations in that have these unintended consequences.

What I am going to do after this hearing—I have got, like, four or five already that we need to, like, really focus on getting these regulations so that they are more holistic in the way they are being applied, with keeping an eye on costs.

Yes, Mr. Pim.

Mr. PIM. I would like to add two more, if I could, and you touched on this, as well, but first of all, we would like to see drugs included in the ACO. Right now, they are not, and they are going to become an increasingly bigger part of driving costs for the program——

Senator MCCASKILL. Drugs are not part of the Accountable Care Organizations?

Mr. PIM. No.

Senator MCCASKILL. Wow.

Mr. PIM. Then the other thing is——

Senator MCCASKILL. How did we miss that? Is that pharma?

Mr. PIM. I do not know what to say.

Senator MCCASKILL. Is it pharma? They did not want it?

PANEL MEMBER. It is because it is a separate program, and because they did not have the wherewithal to combine the data at the time to be able to track. I mean, data is really key to the operation of an ACO, and the drug data are on a separate track and it is hard to combine all the data together to get the total cost.

The incentives are terrible, because if you have got—you know, for a Part D plan, they want to try to maximize the efficiency of your use of drugs, but if the use of drugs to manage a chronic condition can save money on visits to the doctor and hospital admissions, then you end up with Medicare saving money on Part A and B, but the Part D plan losing money because they have to spend more on the prescription drugs.

Senator MCCASKILL. Which goes again to the, let us take the lines away. That makes sense.

Yes.

PANEL MEMBER. On that, though, I would say we have been talking actively with CMS around some pilots where we would try to do some innovative programs in Part D and measure the impact that we saw in A and B costs, so movement in the right direction, but, again, we would like to see more, and then the other thing I just wanted to touch on quickly, and you had mentioned this in your testimony, but telemedicine, I believe, would help, as well, in terms of trying to balance the supply and demand of providers.

Senator MCCASKILL. In terms of the availability and the reimbursable——

PANEL MEMBER. Specifically, the reimbursement of it.

Senator MCCASKILL. Yes. Yes. I am trying to look and see if there is anything I have missed.

I was struck by your testimony, Mr. Pim, about the thousand Hepatitis patients costing $10 million.

Mr. PIM. A hundred million.

Senator MCCASKILL. A hundred million, I mean.

Mr. PIM. Sorry.

Senator MCCASKILL. A hundred grand a piece.

Mr. PIM. Yes.

Senator MCCASKILL. Who paid for that?

Mr. PIM. Medicare did. Taxpayers.

Senator MCCASKILL. And why is it so expensive?

Mr. PIM. Uh——

Senator MCCASKILL. I mean, that is just the medicine?

Mr. PIM. That is the medicine. It was an extraordinarily expensive drug——

Senator MCCASKILL. Why is it extraordinarily expensive?

Mr. PIM. We can follow-up with some information. We can provide more information to your office. It is a point that we have been trying to make for some time now. The drug does treat a con-

dition that beforehand really did not have an effective treatment, but we just believe that the price was exorbitant and unsustainable from a program perspective.

Senator MCCASKILL. Is it just certain kinds of Hepatitis that need this drug, or——

Mr. PIM. Hepatitis C.

Senator MCCASKILL. Hepatitis C. Are there a lot more people that have this drug? I mean, you said you treated a thousand. Is that because very few people have Hepatitis C, or just these are the only ones that——

Mr. PIM. The drug came on the market last year, and so we were limited in our ability to put some controls in place, and so, thus, a thousand patients consumed approximately $100,000 worth of drugs each.

Senator MCCASKILL. That is how much per dose? I mean, that is ten grand a month, almost.

Mr. PIM. Well, it is, depending on the genotype, it is an eight- or a twelve-week course of treatment, so it is actually even more expensive than that on a monthly basis.

Senator MCCASKILL. I see. I see.

PANEL MEMBER. Yes, Senator. I may have this wrong, but I think I remember hearing a CMS official announce that they had spent $4.6 billion on Hepatitis C drugs last year, and it is a good question how much it costs, but again, one of the ramifications of separating the program into different parts is, for all we know, that hundred thousand dollars apiece in drugs, since it appears to be very effective in addressing Hepatitis C, may be saving more money than that, but that savings does not accrue to the Part D plan. It accrues to A and B, and in any case, I think we need more study as to what the appropriate, you know, what the tradeoff is between the spending and the savings overall.

Senator MCCASKILL. Well, we are going to——

PANEL MEMBER. I would argue that it is going to be hard to save a hundred million dollars on those patients. I believe my colleague was mentioning to you right before we started that this drug was going to be approximately $30,000 for each patient, and then through a transaction, the price ultimately went up to almost $100,000.

Senator MCCASKILL. Yes, and that is one thing we are going to do an investigation on, both in the Aging Committee and the Permanent Subcommittee on Investigations, looking at mergers and acquisitions in the pharmaceutical area and what that has done to the price of escalating drugs, because we see the same drugs, and when one company gets acquired by the other, all of a sudden, it doubles. Then it gets acquired by another, and all of a sudden it quadruples, and all they have done is change the label. Something is up there, and I want to try to track that and get to the bottom of it and expose it, because I have a feeling the taxpayers are the ones paying those bills.

Why is your waiver so far away on—why 2017? If they have agreed to give you a waiver, why do you have to wait so long to get it?

Ms. VAN TREASE. As we understand it, there is an implementation challenge as it applies to getting that waiver fully vetted

through the process. We are very happy to have the waiver, and——

Senator MCCASKILL. You do not want me to complain, because you are afraid they will take your waiver away.

Ms. VAN TREASE. I am very happy to have the waiver.

Senator MCCASKILL. By the way—too late.

Ms. VAN TREASE. I would love to have the waiver sooner——

Senator MCCASKILL. I will complain, and if they try to take your waiver away then, then I will really complain.

Ms. VAN TREASE. There you go. There you go.

Senator MCCASKILL. That does not make sense to me. If they have made the determination that this is appropriate, then it sounds to me that that is gobbledygook that would delay it for a year and a half before you would actually get it.

Ms. VAN TREASE. Right. The waiver would be effective, as I said, January 2017. The contract period, the contract year to which I am referring actually begins January 2016, so perhaps one could argue, since the new contract period does not start, that is why the waiver would not start.

Senator MCCASKILL. Dumb.

Ms. VAN TREASE. However, I would more than welcome an early application.

Senator MCCASKILL. Yes. I will look into that. We are getting—believe me, we are taking notes today, so I have got a list of things to do.

I know some of you have obligations that you have to go, so many of the questions I had, you covered in your testimony. Is there anything else that we have not talked about that you believe needs to be brought up as we look at the next 50 years of Medicare and how people see Medicare?

I do think that we still have a lot to do in terms of educating people about what their benefits are that sometimes things that feel free are not free, and sometimes benefits that are badly needed are not available, and if we could get those two things reconciled and stop the over-utilization of some things that are not necessary versus adding dental, or adding certainly hearing.

I think that discoveries that have been made—and I might also bring out that there is going to be a National Geographic program. We have got to keep investing in NIH. It is important in St. Louis for Washington University, but it is important in the whole country. I had CEOs of multinational corporations talking about how important NIH is to America's security, because the strength of our country, the attractiveness of our country has to do with our innovation and our commitment to higher education and research.

I was part of a program, because of my role on the Aging Committee, where some scientists have figured out that there is an available drug right now, and they just got an approval for the NIH testing, that you could take, and it does not prolong your life, but it delays the onset of some of the chronic illnesses that occur near the end of life. Incredibly exciting, and this is not a drug that has to be developed, this is a drug that is currently available, prescribed, obviously, for another purpose.

It is going to—I was just in a room talking to them. I think they just wanted somebody that did not know all their jargon to ask

them common sense questions, because when you leave these three doctors to talk to themselves, it is sometimes like, you guys—I am not sure that everybody knows what ACO or palliative care is, so I try to make sure everybody understands. It will be on the National Geographic channel, and this is—believe me, I am not any expert, I am just there kind of as a prop.

These scientists are very impressive and it is very exciting, but it brings about the other issue that we talked about, and that is if, you know, the longer we live, the more expensive Medicare is, and so we have got to make sure that we continue to make sure we keep it strong and financially viable.

Is there anything else any of you would like to add? Yes, Mr. Richtman.

Mr. RICHTMAN. You know, I want to just make a comment about the death panels. I think a lot of good Members of Congress lost their seats because of the scare tactic of death panels. You know, I do not know how it should have been addressed, but someone needed to confront Sarah Palin, because she really went to town on that, and I think it hurt the effort to improve these programs, health care programs, even more. I think you should be riding roughshod, to use your term, on those kinds of scare tactics, because you can counter that.

Senator MCCASKILL. It is frustrating, because I spent a lot of time trying to correct information that was out in the public domain about what was and was not in the Affordable Care Act, and believe me, it is not perfect, and I am the first one that is anxious to get to the table and make some fixes that I think would be important. I have had a lot of talks with some of you about readmission, other things, the size of businesses, you know, the 50 versus 100, the 30-hour week versus the 40-hour week.

Unfortunately, we have not had any partners willing to make it better, because it has been a political two-by-four and it has been used very effectively, so they have had a tendency to focus on it being bad, not let us try to fix it and make it better.

I joked one day that they have been saying, "repeal and replace" for five years. I am going to get some bloodhounds and I am going to go through the halls of Congress looking for replace, because I have never seen it. I do not know what it looks like. I would not know it if it walked up and shook my hand. "Replace" is the most often mentioned thing in Washington that has never, ever surfaced. There is not a replace, and so, what we ought to do is focus on fix, and in the process, maybe we could adopt some of the things we talked about today.

The record for this hearing will remain open for another two weeks, which means there might be questions for the record for all of you, particularly from some of my colleagues that are not here today but are on the Committee. They were all very interested in this hearing.

I once again want to thank my colleague, Susan Collins, who is the Chairman of the Committee. She and I work very closely together, as I said in the opening statement, and she was very enthusiastic about this hearing occurring.

There will be questions for the record. If there is anything else you would like to put in the record, we welcome that, and I will

make sure that all the members of the Committee have access to it.

Thank you all very much for being here.

[Whereupon, at 2:36 p.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

MEDICARE AT 50: AN EVOLVING PROGRAM FACES THE FUTURE

Stuart Guterman

Senior Scholar in Residence

AcademyHealth

Invited testimony

U.S. Senate

Special Committee on Aging

Field Hearing Commemorating the Medicare Program on its 50th Anniversary

St. Louis, MO

July 31, 2015

This testimony draws heavily on publications written by or co-authored with my former colleagues and grantees at the Commonwealth Fund.

The views presented here are those of the author and not necessarily those of AcademyHealth or the Commonwealth Fund or their directors, officers, or staff.

MEDICARE AT 50: AN EVOLVING PROGRAM FACES THE FUTURE

Thank you, Chairman Collins, Senator McCaskill, and Members of the Committee, for this invitation to testify on the current state of Medicare and the challenges it faces as it enters its second 50 years. I am Stuart Guterman, a Senior Scholar in Residence at AcademyHealth. AcademyHealth is an organization that works to improve health and the performance of the health system by supporting the production and use of evidence to inform policy and practice.

I am glad to be able to speak to you on this topic, because I have been working on Medicare issues for a long time, at the Commonwealth Fund from 2005 until recently, the Centers for Medicare and Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration, in the mid-1980s and again from 2002 to 2005, and at the Medicare Payment Advisory Commission (MedPAC) and its predecessor, the Prospective Payment Assessment Commission, from 1988 to 1999, as well as at the Congressional Budget Office (CBO). I have seen—and had the privilege of participating in—the innovative changes that the program has implemented over the years, and also been aware of the challenges faced by the program.

In addition, many of us with elderly parents or other loved ones know how they have been helped tremendously by Medicare's coverage and the access to care it provides—and also hindered by the program's shortcomings and the fragmented nature of health care provided in this country.

As Medicare celebrates its 50th anniversary, it has been a tremendous success in accomplishing its main goal: assuring the health and economic security of the nation's elderly and disabled. It is very popular with its beneficiaries, and has been influential in shaping the U.S. health system, improving the quality of care, and contributing to medical progress.

At the same time, Medicare faces considerable challenges. Rising costs, affecting both the federal budget and beneficiaries, are an ongoing challenge. Medicare's benefit package, while rated highly by beneficiaries for enabling their access to care and protection from financial hardship and medical debts, falls short in providing financial protection for beneficiaries with low incomes and serious health problems. Fragmentation of coverage into different plans for hospital, physician, and prescription drug benefits is confusing for beneficiaries and undermines coordination of patient care; and because Medicare covers only a portion of medical expenses, most beneficiaries supplement Medicare with other coverage, adding to complexity and administrative cost. Better strategies are also needed to serve the growing number of beneficiaries with complex care needs with physical and cognitive functional limitations and multiple chronic conditions—symptoms of an aging population.

We currently have an unprecedented opportunity—and a historic imperative—to continue to improve the program and its ability to serve its beneficiaries over the next 50 years. In this testimony, I first discuss Medicare's evolution over its first 50 years and then describe the issues that must be addressed to make the program more effective and viable into the future.

ORIGIN AND IMMEDIATE IMPACT

To consider Medicare's current state and the challenges it faces, we need to consider the environment in which it was enacted and the problems it was intended to address, as well as how it has changed over time. Medicare was enacted only after a long and contentious struggle. National health insurance was advocated by President Harry S. Truman in the late 1940s, but by the 1950s and early 1960s, efforts had focused on the particularly egregious needs of America's elderly population.[1]

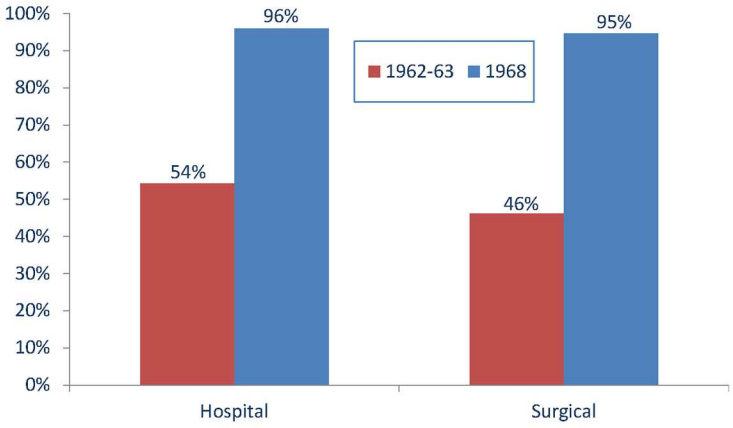
The elderly were of great concern because they tended to be in poorer health than younger Americans and have greater health care expenses. They also faced financial barriers that hindered access for the care they needed: in the mid-1960s, only about half of all Americans age 65 and older had health insurance. Employer-sponsored health insurance, the major vehicle for health insurance coverage in the U.S., was unavailable to many retirees; also, the elderly were less attractive to health insurers because they presented a greater risk for high costs.

On July 30, 1965, President Johnson signed the Social Security Amendments into law, creating Medicare (Title XVIII) and Medicaid (Title XIX). When the program was implemented in 1966, it had an immediate impact:

- Health insurance coverage for the elderly increased from about 50% to almost 100% (Exhibit 1).
- Access to health care for the elderly increased, and disparities by race declined sharply (Exhibit 2).

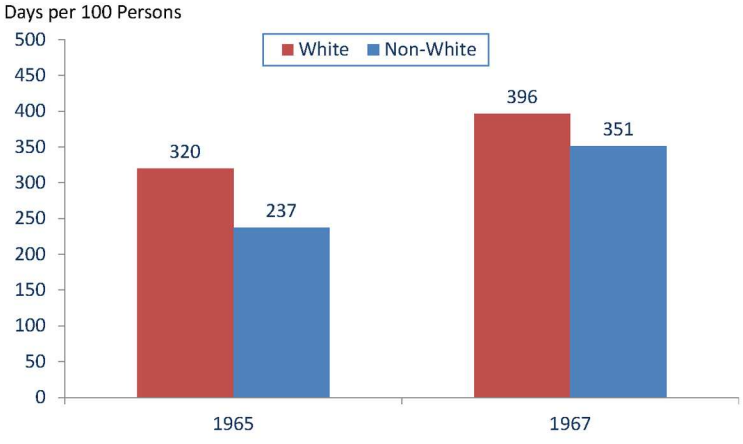
- Out-of-pocket spending by the elderly as a proportion of total charges fell from 77% to 47% (Exhibit 3).

Exhibit 1. Percentage of Persons Age 65 and Over With Hospital and Surgical Insurance, 1962-63 vs. 1968 [1]



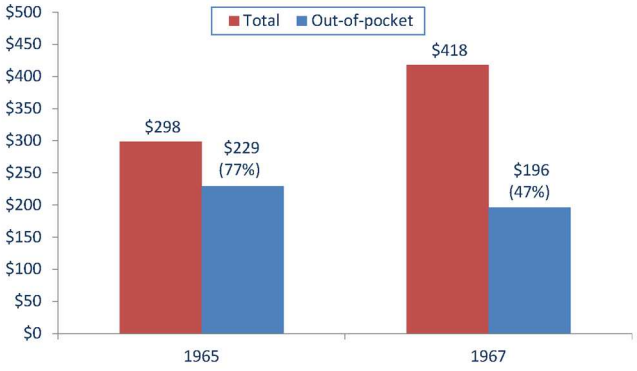
Source: R.A. Cohen et al. "Health Insurance Coverage Trends, 1959-2007: Estimates from the National Health Interview Survey." *National Health Statistics Reports* Number 17, July 1, 2009.

Exhibit 2. Short-Stay Hospital Utilization by Persons Age 65 and Over, by Race, 1965 and 1967 [2]



Source: R. Loewenstein. "Early Effects of Medicare on the Health Care of the Aged." *Social Security Bulletin* April 1971 34(4).

Exhibit 3. Mean Total Charges for Health Care and Out-of-Pocket Payments by Persons Age 65 and Over, 1965 and 1967[3]



Source: R. Loewenstein. "Early Effects of Medicare on the Health Care of the Aged." *Social Security Bulletin* April 1971 34(4).

Medicare also was instrumental in desegregating hospitals throughout the country, as receipt of Medicare payment was contingent on the elimination of segregation of hospital facilities and hospital staffs.[2]

MEDICARE COVERAGE

Original Medicare consisted of Hospital Insurance (HI, or Part A), which covered primarily hospital care for everyone eligible for Social Security retirement benefits and is financed by payroll taxes contributed to the Hospital Insurance Trust Fund, and Supplementary Medical Insurance (SMI, or Part B), which covered primarily physician and other ambulatory care for every Medicare-eligible person who does explicitly choose not to participate and is financed by a combination of premiums and general tax revenues.

The Social Security Amendments of 1972 extended Medicare eligibility to persons under age 65 who qualify for Social Security benefits as permanently disabled (coverage begins 24 months after eligibility for disability benefits) and persons with end-stage renal disease (ESRD; coverage begins in the fourth month after dialysis treatments and extends for 36 months after a kidney transplant). In 2014, 8.9 million of the 53.8 million Medicare beneficiaries were eligible because of their disability status or ESRD.[3]

The Medicare Modernization Act of 2003 made drug benefits available to Medicare beneficiaries beginning in 2006, under Medicare's prescription drug coverage (Part D) program. Part D coverage is voluntary, and available only through private prescription drug plans; premiums (heavily subsidized by Medicare) are paid directly to the plan, with additional subsidies available for beneficiaries with low incomes. In 2014, 37.8 million beneficiaries had prescription drug coverage through Medicare and another 2.7 million received retiree drug coverage under Part D.[4]

EXPANDING CHOICE FOR MEDICARE BENEFICIARIES

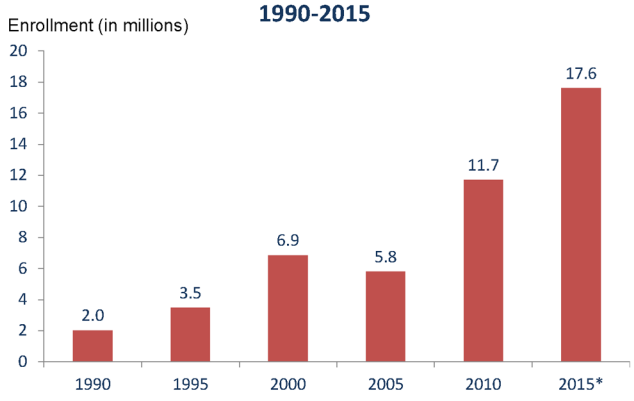
As an alternative to traditional Medicare, beneficiaries can obtain their Part A and Part B coverage (and Part D as well) through private health insurance plans. The Tax Equity and Fiscal Responsibility Act of 1982 created the Medicare Risk Program, making private health maintenance organizations (HMOs) and similar plans available to Medicare beneficiaries. Enrollment initially was small, but it grew rapidly in the mid-1980s as managed care became more popular in the private sector as well.

In 1997, the Balanced Budget Act created a new Medicare+Choice program to emphasize private plans as an option for beneficiaries. However, cuts in payment rates under traditional Medicare reduced private plan rates as well, causing many plans to leave the program. In addition, enrollment fell with the managed care backlash of the early 2000s.

The Medicare Modernization Act of 2003 created the current Medicare Advantage program, increasing plan payments and adding more types of plans. The sharply increased payment rates attracted more private plans, and the additional benefits that plans were able to offer because of the high payment rates attracted more beneficiaries. In 2015, an estimated 17.6 million beneficiaries—more than 30 percent of the Medicare population—obtain their Medicare benefits through private Medicare Advantage plans (Exhibit 4).[5]

4

Exhibit 4. Medicare Enrollment in Private Health Plans, 1990-2015



*2015 projected.
Source: Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds. "2015 Annual Report." (Washington, DC: The Trustees, July 2015). Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf.

EARLY PAYMENT REFORMS

When Medicare was enacted in 1965, it adopted payment methods modeled after prevailing private insurance practices at the time. Hospitals were reimbursed for their allowable costs, and physicians were paid based on local prevailing charges. There were no incentives for providers to control costs—the more providers spent, the more they were paid. Over the years, Medicare has implemented changes in how it pays providers, generally moving from cost-based reimbursement to prospective payment; but it still pays predominately on a fee-for-service basis—the more services that are provided and the more complex they are, the more the provider gets paid, regardless of how much those services contribute to the health of the patient.

The Social Security Amendments of 1983 established a prospective payment system for inpatient hospital care, with payment based on prospectively set rates for cases in each diagnostic-related group (DRG). This was a dramatic change in how hospitals were paid: it established the hospital stay as the unit of payment, and provided higher payment rates for more costly types of patients and in areas with higher input costs, rather than basing payment on the hospital's own costs. DRGs changed the focus of hospital payment in the U.S.,[6] and they have been adopted widely in other countries, as well.[7] But they only include hospital services during the hospital stay, and so do not encourage coordination of care across providers and settings.

The Omnibus Budget Reconciliation Act of 1989 replaced reimbursement based on prevailing charges with a physician fee schedule based on a Resource-Based Relative Value Scale (RBRVS), which is intended to reflect the relative cost of providing each

physician service. In addition to setting the rates that Medicare would pay, this legislation limited the extent to which physicians could 'balance bill' patients for the difference between their own charges and the Medicare payment rate.

The RBRVS was intended to correct a perceived overemphasis on procedures relative to diagnostic services—but there has been persistent dissatisfaction with the process for setting the relative values. Nonetheless, it was widely adopted by private payers in the U.S.

FROM UTILIZATION REVIEW TO QUALITY IMPROVEMENT

Medicare has long had a mechanism in place to make sure that its funds were being used effectively and that its beneficiaries received care consistent with medical quality standards. The Social Security Amendments of 1972 created the Professional Standards Review Organization (PSRO) program to review the appropriateness of services reimbursed through Medicare—but the PSROs were viewed as primarily focused on utilization review rather than quality improvement.[8] Ten years later, the PSROs were replaced by Peer Review Organizations (PROs)—but the primary emphasis continued to be on utilization review.

In 1992, Medicare launched the Health Care Quality Improvement Program (HCQIP), shifting the focus of the PRO program to working with providers to improve health care.[9] In 2002, the HCQIP was expanded to include nursing homes and home health, and the PROs were renamed Quality Improvement Organizations (QIOs).

In the early 2000s, greater emphasis was put on the need to improve health care quality through measurement and payment.[10] Medicare has implemented a series of initiatives aimed at providing information on quality measures to empower beneficiaries in choosing providers and enable providers to identify areas in which their performance could improve, including quality measures for hospitals, physicians, nursing homes, home health agencies, and dialysis facilities. Expanded use of health information technology was encouraged in 2004 by the issuance of an Executive Order creating the Office of the National Coordinator for Health Information Technology and substantially enhanced by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009.[11]

CONTINUING EVOLUTION

Medicare has made significant improvements in the original payment methods modeled on the private insurance payment practices of the 1960s, and recent actions by Congress and the Department of Health and Human Services (HHS) have focused on accelerating that change.[12] The Affordable Care Act of 2010 includes an array of provisions that are laying the foundation for fundamental Medicare payment reform, linking payment to patient outcomes and experiences of care, and giving providers an incentive to limit spending by rewarding reductions in the projected spending for their Medicare patients.[13]

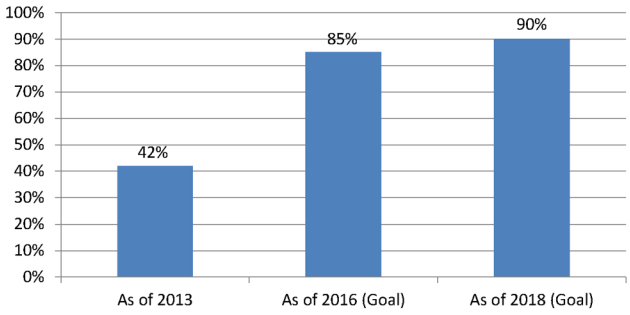
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), passed only a few months ago, pushed Medicare payment reform further forward by repealing

the sustainable growth rate formula (SGR), which was established to determine the annual update in Medicare physician payments.[14] The SGR was intended to counter the tendency of fee-for-service payment to reward volume and intensity rather than appropriateness, quality, and desirable outcomes, but it was widely criticized because it produced large, across-the-board cuts in physician fees, hindered attempts to reform payments, and failed to control cost growth. MACRA put in place modest increases in physician fees, with strong rewards for high performance and incentives to participate in alternative payment models that reward value.

In addition, the Secretary of HHS has set a goal of linking 85 percent of traditional Medicare provider payment to quality or value by the end of 2016, and 90 percent by the end of 2018.[15] A recent study indicates that, as of the end of 2013, 42 percent of provider payments in traditional Medicare are tied to the value of care. This represents significant progress, but much still remains to be done (Exhibit 5).[16] Many initiatives that were not included in that study are in place now or will soon be implemented, supporting expectations that the percentage will increase considerably over the next few years.

Also noteworthy is that Medicare Advantage plans, which cover over 30 percent of Medicare beneficiaries, are now financially rewarded for receiving a high rating based on their performance on measures of quality and patient experience.[17] Although little is known about how Medicare Advantage plans actually pay their providers, the addition of rewards for plan performance to the existing incentive for efficiency in a per-enrollee per-month payment system can be expected to support the move from volume to value in Medicare.

Exhibit 5. Percentage of Traditional Medicare Payment Tied to Quality or Value, and Goals for the Future



Source: Catalyst for Payment Reform. "First-of-Its-Kind Scorecard on Medicare Payment Shows Widespread Payment Reform." Press release, May 5, 2015; available at http://www.catalyzepaymentreform.org/images/Press_Release_Scorecard_on_Medicare_Payment_Reform_final.pdf; Sylvia M. Burwell. "Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care." *The New England Journal of Medicine* March 5, 2015 372(10):897-99.

ONGOING CHALLENGES

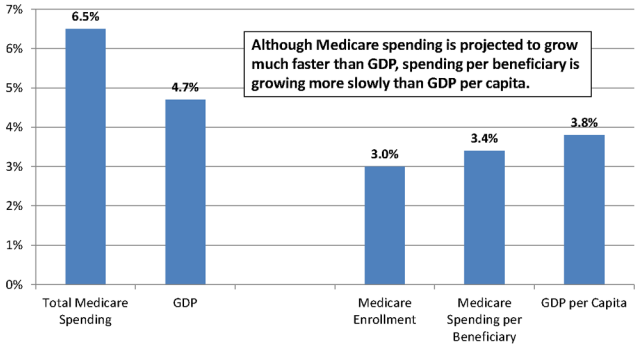
Despite its accomplishments, Medicare continues to face challenges, some of which are specific to Medicare and others—such as rising costs—that are faced by public programs and private payers alike. The future of the program and its ability to continue to provide access to high quality care to its beneficiaries will depend on how policymakers, health care providers, and beneficiaries themselves respond to these challenges—but success will require changes not only to Medicare, but across the health system.

Spending Growth. Medicare accounts for one-fifth of national health spending.[18] Like the rest of the health system, it has been plagued by rapidly rising costs. Medicare also is an important part of the federal budget, accounting for more than one-sixth of federal spending.[19] In 2009, Medicare was spending an average of $11,723 on

46.6 million beneficiaries, and the Medicare HI Trust Fund was projected to become insolvent by 2017.[20] Spending per beneficiary has slowed dramatically in recent years, growing at only a 1.3 percent annual rate from 2009 to 2014, and the projected solvency of the HI Trust Fund has been extended to 2030.[21]

Still, Medicare faces a great challenge as the "boomer" generation born after World War II ages into coverage—by 2030, the number of beneficiaries is projected to rise more than 50 percent, from 53.8 million to 81.7 million, prompting concern about how to respond to the rising share of the federal budget and the nation's resources that will be devoted to financing health care for the elderly and disabled. Although spending per beneficiary has been growing slowly in recent years, and is projected to grow slowly for the immediate future, the increasing number of beneficiaries will drive Medicare spending to grow faster than the economy as a whole (Exhibit 6).

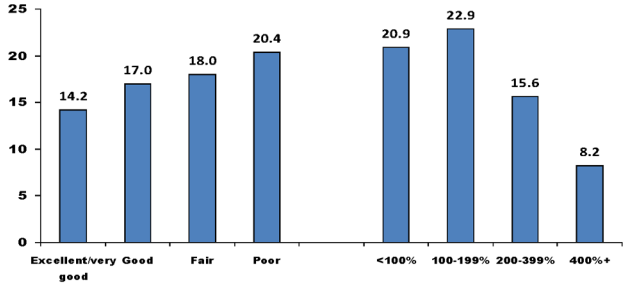
Exhibit 6. Projected Annual Growth Rates for Total Medicare Spending, GDP, Medicare Enrollment, Spending per Beneficiary, and GDP per Capita, 2013-2023



Source: Centers for Medicare & Medicaid Services, Office of the Actuary. National Health Expenditure Projections, 2013-2023.

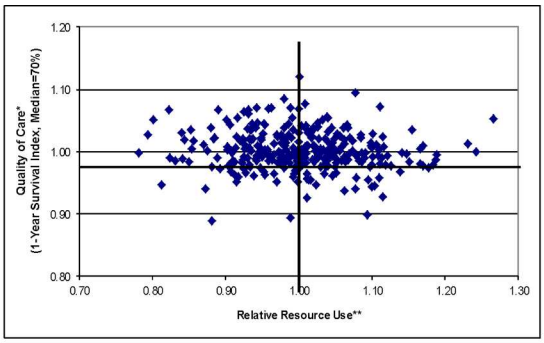
Policymakers are confronted, therefore, with the question of how to continue to slow the growth of total Medicare spending when the spending per beneficiary already is increasing so slowly. Shifting more of the cost of meeting their health care needs onto beneficiaries themselves is problematic, however, since the aged and disabled include some of the poorest and sickest Americans, and they are least prepared to bear that additional burden (Exhibit 7).

Exhibit 7. Median Out-of-Pocket Health Spending as a Percent of Income Among Medicare Beneficiaries, by Health Status and Income, 2006



SOURCE: T. Neuman, J. Cubanski, J. Huang, and A. Damico. "How Much Skin in the Game Is Enough? The Increasing Financial Burden of Health Spending for People on Medicare." Kaiser Family Foundation Data Spotlight, June 2011.

By now, the wide variation in both Medicare and private sector spending is well-documented.[22] In Medicare, particularly, the lack of association between high spending and better quality and outcomes across the U.S. indicates that there should be ways to control spending while maintaining quality (Exhibit 8). Supporting comprehensive payment and delivery system changes that produce lower costs and better value, not just in Medicare, but across the entire health system, would go a long way to increasing value.



xed to risk-adjusted 1-year survival rate (median=0.70).
c-adjusted spending on hospital and physician services using standardized national prices.
E. Fisher, J. Sutherland, and D. Radley, Dartmouth Medical School analysis of data from a 20% national sample of Medicare ciaries.

e: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the al Scorecard on U.S. Health System Performance, 2008*, (New York: The Commonwealth Fund, July 2008).

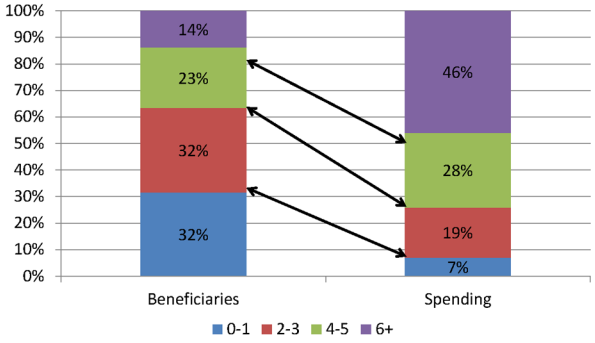
Benefit Design. Currently, Medicare beneficiaries who enroll in traditional Medicare must patch together multiple plans to receive adequate financial protection and prescription drug benefits. This creates complexity and confusion for beneficiaries and results in higher administrative expenses because of the multiple insurance carriers involved and the lack of integrated claims administration. The need to obtain coverage from multiple sources also makes it difficult for Medicare to incorporate value-based benefit designs that use patient cost-sharing to provide incentives to seek high-value care and compare alternative treatment choices. By offering separate medical and drug coverage, the current design creates a disincentive to achieve hospital and specialty care savings through appropriate medication management. The availability of first-dollar supplemental coverage in the current Medigap market makes it difficult for Medicare to adopt incentives for beneficiaries to register and seek care from primary care practices

and medical home teams or seek care from accountable health care systems with a track record of high quality and lower costs.

The combination of fragmented and first-dollar coverage thus raises total cost and confronts beneficiaries with complex choices at high administrative expense. And current benefits fail to protect beneficiaries from catastrophic out-of-pocket costs if they cannot afford private supplements. The only option available to beneficiaries who want integrated comprehensive coverage is to enroll in a private MA plan, with a more limited provider network. A more comprehensive Medicare benefit design that offered could simplify and strengthen beneficiary protection and complement the payment and system reforms that are needed to control costs and improve value.[23]

Care for Beneficiaries With Complex Conditions. A related issue is that Medicare itself was created primarily to provide acute care—essentially short-term treatment for a specific illness, injury, or procedure, and to aid in recovery from that condition. In 1960, life expectancy at birth in the U.S. was 70; in 2010, it was 79.[24] As both medical science and health care delivery have changed, so have the needs of Medicare beneficiaries. Now, 37 percent of Medicare beneficiaries have 4 or more chronic conditions—those beneficiaries account for 74 percent of total Medicare spending (Exhibit 9). Medicare increasingly has focused on improving the coordination of care across providers and settings, and hopefully, proposals will be developed to address those issues and to serve the needs of these beneficiaries more effectively and more efficiently.[25]

Exhibit 9. Beneficiaries with Multiple Chronic Conditions Account for a Disproportionate Share of Spending in Traditional Medicare (2009 Data)



Source: Centers for Medicare & Medicaid Services. "Chronic Conditions Among Medicare Beneficiaries Chartbook: 2012 Edition." Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.

A notable gap in almost all proposed Medicare reforms is the absence of practical, affordable ideas for covering long term services and supports (LTSS) that are increasingly important for the aging Medicare population. While Medicaid pays for such care for impoverished beneficiaries, no comparable support is available for non-poor older and disabled Americans. Further, the fragmentation of acute care and LTSS makes it difficult to finance and deliver coordinated acute and LTSS. Solutions will likely require new sources of revenue that are difficult to find from public sources, and private insurance has struggled to fill this gap.[26]

Balancing the Roles of Traditional Medicare and Medicare Advantage. An ongoing issue is the appropriate balance between public traditional Medicare and private Medicare Advantage plans. A goal of the Medicare private plan program since its inception in 1982 has been to provide a more efficient model of care to beneficiaries than

the unorganized fee-for-service-based payment system used by traditional Medicare. Expecting that private plans had the potential to be more flexible and efficient than FFS Medicare in meeting the needs of their enrollees, Medicare originally set payment rates for these plans at 95 percent of per beneficiary costs in traditional Medicare in each county, but the tendency for private plan enrollees to be less costly than other beneficiaries meant that plan payments were higher than the same enrollees would have been expected to cost in traditional Medicare.[27]

The relationship between private plan payments and county-specific spending in traditional Medicare has been loosened somewhat, and payments to Medicare Advantage plans are now risk-adjusted to reflect the relative costliness of their enrollees. But Medicare Advantage plan payments overall still exceed traditional Medicare spending in much of the country, and that relationship varies not only by geographic area but also by type of plan. HMOs are the only type of MA plan with lower average costs per enrollee nationwide than traditional Medicare, and there is wide variation in both efficiency and quality among individual plans.[28]

A succession of policy changes over the past 30 years has resulted in substantial overpayment to Medicare Advantage plans relative to anticipated per beneficiary spending in traditional Medicare, and dilution and distortion of incentives to encourage the efficiency or effectiveness of which Medicare Advantage plans should be capable. The recent adjustments to payment policies has strengthened the relationship between plan payment and plan performance, and leveled the playing field between traditional Medicare and Medicare Advantage to some extent.[29] With more than 30 percent of

Medicare beneficiaries enrolled in private plans—a growing number, but still a minority—it becomes increasingly important to determine the appropriate balance between traditional Medicare and Medicare Advantage, and to develop policies that bring out the best in both programs for the benefit of this and future generations of Medicare beneficiaries and to ensure the continued viability of the Medicare program.

CONCLUDING THOUGHTS

Medicare has been successful in achieving its basic mission—providing access to care and stable coverage to aged and disabled Americans. But, as the country's largest purchaser of health services, it can do more to improve quality, promote more coordinated care, and control costs—both its own and throughout the health system. Because of Medicare's unique position, it can be an important testing ground for cost and quality innovations. Policies have been put in place that encourage such development, including expanding the power of the Secretary of Health and Human Services to put payment pilot programs on a "fast track" and to work with private payers and providers to establish multi-payer initiatives.

Medicare is a program that is extremely successful, popular, and important to its beneficiaries, but can be improved in several ways and, at the same time, fulfill its larger role as a key part of health care reform and a platform for improvements that can address the problems that it has in common with the rest of the health care system: the need for increased value for the dollars spent on care.

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Testimony of

Brit Pim
Vice President, General Manager – Government Programs
Express Scripts

Before the

Senate Special Committee on Aging
Field Hearing

Celebrating Medicare: Strengthening the Program for the Next 50 Years

St. Louis, Missouri
July 31, 2015

Senator McCaskill and other Members of the Special Committee on Aging, thank you for the opportunity to share with you Express Scripts' perspective about the success of Medicare Part D and opportunities to make the program work even better for current and future beneficiaries.

My name is Brit Pim and I am the General Manager of Express Scripts' Government Programs Division, which includes Medicare, Medicaid and Health Care Reform. When I joined Express Scripts more than a decade ago, Medicare prescription drug coverage was uncharted territory. I am proud to be part of the team that helped Express Scripts and our clients successfully launch multiple Part D plans for millions of beneficiaries.

As background, Express Scripts is the nation's largest pharmacy benefit manager serving more than 85 million Americans with coverage through self-insured plans, health plans, Taft-Hartley union plans, state-employee benefit plans, Medicare, Medicaid, state and federal Marketplace plans, the Children's Health Insurance Plan (CHIP), workers' compensation arrangements, and other plans. In 2014, Express Scripts managed more than 1.3 billion pharmacy encounters for our patients and clients, thereby providing us with an unparalleled insight into what works best in pharmacy management.

In the past decade, our Medicare prescription-drug expertise has grown tremendously. In Medicare, Express Scripts provides comprehensive pharmacy benefit services to more than 7 million beneficiaries. Express Scripts partners with Medicare Advantage plans to provide enrollees a Medicare Advantage Prescription Drug Plan (MA-PD). Express Scripts also offers its own stand-alone Prescription Drug Plan (PDP). Lastly, we provide a prescription drug benefit to retirees through Employer Group Waiver Plans (EGWPs).

By every objective measure, the Part D program is working as Congress intended:

- Seniors have saved money on their prescription drugs – more than $7 billion;
- Taxpayers have saved money –program costs are 45% below initial projections;
- Seniors are happy with their prescription drug benefit – 94% report being satisfied and 95% believe coverage meets their needs.

As we celebrate Medicare's 50th anniversary of providing stable and secure coverage to millions of seniors and disabled beneficiaries, we believe now is also the time to examine what is working here and now and to highlight opportunities for improving the program.

US Prescription Drug Spending Increasing at Highest Rate Since 2003

On average, a Medicare beneficiary is taking six medications at any given time. Fully 15% of seniors take *10* prescriptions at the same time. Medicare beneficiaries are the highest utilizers of prescription drugs and thus particularly sensitive to prescription drug price increases. In 2014, our data show that US prescription drug spending overall increased 13.1% – the largest annual rate of increase since 2003. This increase was driven largely by an unprecedented 31% increase in spending on specialty medications. Express Scripts has segmented Medicare prescription drug spending to provide a more detailed picture of costs and utilization:

- The total drug spend for Medicare plans increased 13.8% in 2014, to $2,987.96 per beneficiary, as a result of a modest increase in utilization, 0.5%, combined with a steep 13.3% increase in unit costs.

- Traditional drug spending, defined as drug spend for the top ten conditions, increased 6.4%, driven by relatively stable utilization and a 5.9% increase in unit costs.

- While specialty medications now account for about one-quarter of all Medicare drug spend, their contribution to overall Medicare trend is significant: Medicare specialty spend increased 45.9%, compared to a far more modest increase of 14.7% in 2013 and a stark difference to the 12% trend seen in 2010 for specialty medications.

While prescription drug costs are rising at the fastest rate in over a decade, Express Scripts has a number of tools and techniques available to slow trend, improve adherence, and generate better outcomes. Depending on client preferences and marketplace rules, Express Scripts can provide a customized offering of services and products tailored to individuals' needs.

Pharmacy Networks

Express Scripts has been a pioneer in creating preferred retail pharmacy networks that effectively align beneficiary and Medicare program priorities. For decades, doctors, hospitals, and other providers have been routinely designated as either preferred or non-preferred – a strategy which aligns the best interests of the patient, the provider and the plan sponsor. Without a preferred pharmacy strategy, plan sponsors and members are exposed to higher drug spend. With about 65,000 retail pharmacies nationwide to draw upon in setting up preferred pharmacy networks – including chain drugstores, independent pharmacies, grocery store pharmacies, and "big box" retail pharmacies – beneficiary pharmacy access has never been more robust.

Express Scripts' preferred retail pharmacy network, known as Express Advantage Network®, offers patients about 34,000 retail pharmacies. In fact, Express Scripts research confirms preferred network pharmacies are, on average, nearly one mile *closer* to the patient's home than the patient's current pharmacy: the average patient lives 2.6 miles from a preferred pharmacy and 3.4 miles from the pharmacy he or she most frequently uses.

At the macro level, industry studies have shown that Medicare Part D plans with preferred pharmacy networks offer high quality benefits with lower-than-average premiums, and significantly reduce Medicare spending. Recent research also debunks claims about access, documenting how the average beneficiary need only travel about one extra mile to use a preferred retail pharmacy to save $20-$40 on monthly cost sharing – a significant savings for an individual on a fixed income. A 2013 study by Milliman estimated that preferred pharmacy network plans will reduce federal Medicare spending by up to $9.3 billion over 10 years.

A Pembroke Consulting analysis of newly released 2015 CMS enrollment data shows that 81% of seniors chose Part D plans with a preferred pharmacy network. Further, a recent survey conducted by the Pharmaceutical Care Management Association (PCMA) of 453 Medicare beneficiaries enrolled in a Part D plan with a preferred pharmacy network found that 90% of seniors in rural, suburban and urban areas reported convenient access to a pharmacy in a preferred pharmacy network in Part D. In addition, seniors

in small town and rural areas reported high satisfaction with their Part D plans and the pharmacies in their preferred network.

Express Scripts believes the hallmarks of a successful preferred pharmacy network include:

- A sizable network that complies with CMS standards and ensures patients will not have to travel more than 2 miles in urban areas, 5 miles in suburban areas, or 15 miles in rural areas to access a preferred pharmacy. The Express Scripts Medicare Preferred Network includes more than 28,000 pharmacies nationwide and complies with these standards;

- Diversity in the types of pharmacies provided – chain, grocery and independent community pharmacies;

- A home delivery pharmacy that can offer even greater savings and convenience for maintenance medications; and

- True savings for the patient, both in premium costs and co-pay differential.

Despite the clear value offered by preferred pharmacy networks, retail pharmacy trade groups have pushed questionable data – based solely on a patient's home address – that suggests seniors in urban areas do not have convenient pharmacy access. However, these trade groups' flawed methodology fails to account for *where* a member has historically chosen to fill a prescription when all retail pharmacies were available options. **Once a member's historical preference is accounted for, there is no discernible loss of pharmacy access for plans that transition to a preferred pharmacy network.** Bottom line: Part D preferred networks deliver significant cost savings, while still fulfilling CMS' high standards for pharmacy access.

Formulary

Prescription-drug formularies help create competition in the pharmaceutical marketplace that lowers costs for beneficiaries and taxpayers. Plans rely on independent Pharmacy & Therapeutics committees – comprised of independent physicians, pharmacists, and other experts – to develop clinically based lists of preferred drugs, known as formularies.

While formularies have helped manage Medicare spending, Medicare's rules do not allow plans to leverage all available tools. Unlike commercial health plans, Medicare health plans are not allowed to make mid-year formulary changes to remove high-cost drugs when lower cost, but equally effective, alternatives come to market. While plans can – and do – add new drugs to formularies during the plan year, CMS hampers their ability to remove medications mid-year. Brand-pharma companies have taken advantage of these rules by strategically timing their product launches early in a new plan year to maximize plan coverage – and profits – at the expense of beneficiaries, Medicare, and taxpayers.

Home Delivery Pharmacy

Home delivery pharmacy is a critically important pharmacy option available to Medicare beneficiaries. While individuals taking short-term prescriptions for acute conditions typically go through a retail pharmacy, home delivery is ideal for beneficiaries taking long-term maintenance medications. An increasingly popular choice, home delivery has proven to be a lifeline for beneficiaries with limited mobility and/or limited incomes.

Home delivery typically provides a 90-day prescription that costs less than three 30-day fills at a retail pharmacy. Beneficiaries can save an average of 29% in their out of pocket costs compared to retail. Highly automated, cutting edge-technology allows for 99.99% dispensing accuracy, which data show is higher than retail. Medications with protective and insulated packaging are delivered right to a beneficiary's doorstep. Beneficiaries have 24/7 access to a pharmacist in the comfort and privacy of their own home and automatic refills help improve patient adherence 19% compared to retail pharmacies.

In 2014, Express Scripts conducted the first known, well-controlled, head-to-head comparison of prescriptions dispensed at retail pharmacies and at home delivery pharmacies. The peer-reviewed study, which controlled for socioeconomic status and excluded patients using home delivery automatic refill programs, examined 29 million de-identified claims corresponding to nearly 1 million Medicare beneficiaries taking medication for diabetes, high blood pressure or high cholesterol over a two-year period. **The study found that beneficiaries who receive medication for diabetes, high blood pressure and high cholesterol via home delivery pharmacy are between 25% and 29% more likely to be adherent to prescription drug therapy than patients with these conditions who fill their prescriptions at a retail pharmacy.**[1]

Specialty Pharmacy

With the high cost and complexity of specialty drugs pressuring public and private payers alike, more health plans are turning to specialty pharmacies to help manage the distribution and administration of these medicines. Specialty pharmacies provide a clinical value to chronically ill beneficiaries that cannot be easily replicated elsewhere in the system. In reality, very few pharmacies have the expertise and capacity to manage high-cost, sophisticated specialty medications. For these reasons, Express Scripts has created Therapeutic Resource Centers, which enable our specialty pharmacists and other clinicians such as nurses and nurse practitioners to focus on patients with complex conditions needing specialized pharmacy care.

Express Scripts' Therapeutic Resource Centers (TRC) focus on complex conditions such as cancer, HIV/AIDS, heart disease, high-blood pressure, asthma, bleeding disorders, and diabetes. These centers provide vital clinical support services that enable patients to focus on getting better and managing their conditions. For example, Express Scripts cancer patients have access to a team of specialized pharmacists and nurses that can help mitigate prescription-drug side effects like arthritic pain and nausea, provide nutritional counseling for those with little appetite, and be especially attuned to therapy failure and resistance.

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Waste, Fraud & Abuse

Efforts to combat fraud, waste and abuse are vital to the program's financial sustainability and have grown in recent years in response to the prescription drug abuse epidemic. Each year, this epidemic kills more than 15,000 Americans, drives 1.2 million visits to emergency rooms, and costs payers, including Medicare, billions of dollars.

Express Scripts has led the industry in innovative solutions to reduce the financial and human costs associated with prescription drug abuse. Our cutting-edge programs rely on intensive data analytics to detect fraudulent behavior, proactively identify unusual utilization patterns, ensure compliance with government requirements, and provide actionable evidence for plan sponsors. The problem is real, and so are our solutions to combat them.

Consider the experience of one patient. In 2011, a 49-year old patient filled 43 controlled-substance prescriptions from 17 prescribers and five pharmacies. In a span of just 14 months, this patient received 825 days' worth of medication. An Express Scripts pharmacist worked with the plan to establish a member-level benefit change so that the patient would transition to a single pharmacy and prescriber for her medications. This patient-specific plan also included a nurse case manager and the plan's employee assistance program. Today, the patient has completed a rehabilitation program, sees just one pain management physician, and follows common-sense benefit guidelines. This program has saved the plan sponsor more than $40,000 and may well have saved the patient's life.

Unfortunately, this program is not available to Medicare patients because the program does not have the ability to implement similar controls. Legislation is being considered by Congress that would allow Part D plans to adopt this best practice used in the commercial market and by 46 Medicaid programs. With overwhelming support for this policy, we are optimistic that it will be enacted in this Congress. And that is largely what has made Medicare Part D such a success – plans, lawmakers and regulators continue to innovate in ways to improve the program and protect beneficiaries.

Medication Therapy Management

Medication Therapy Management (MTM) programs play an important role in identifying and assisting beneficiaries at risk for gaps in care. However, only a small percentage of the Medicare Part D population is eligible for MTM according to CMS criteria. Express Scripts' Expanded MTM program applies Health Decision Science™ to leverage behavioral science, clinical specialization, and use of actionable data to target additional members at risk for non-adherence; engage beneficiaries and prescribers; issue clinical alerts; and conduct medication reviews and implement tailored interventions.

Express Scripts relies on other tools as well. Express Scripts' ScreenRx® program has been tailored for the Medicare population. In this market segment, ScreenRx® has a unique effectiveness through a proprietary, Medicare-specific predictive model that identifies seniors who are at future risk of non-adherence, and then customizes support to help seniors overcome behavioral, clinical, and financial barriers to adherence and keep them on course.

Medicare-Medicaid Demonstration

The MMP demonstration provides a landmark opportunity to create a streamlined experience for both provider and member to improve health outcomes while helping to contain skyrocketing healthcare costs. However, streamlined requirements for the plan sponsors seem to have been overlooked, and the lack of aligned requirements from CMS and participating states is hindering the plan's ability to execute demonstration's intent. Many requirements for plan oversight and operations are only included to provide the state and CMS with their preferred reporting formats. Accommodating these variances between state and federal requirements have taken up significant financial resources by the plan that may have been better allocated toward member centric services to improved health outcomes.

Better coordination and alignment of the MMP requirements would lead to more efficiency for all stakeholders. A unified set of demonstration requirements for CMS and all participating states would give plans the ability to focus on processes that improve member outcomes, and would reduce the distraction of duplicative operational requirements that do not provide additional value.

Biosimilars

Spurred by enactment of the Hatch-Waxman Act in 1984, generic drugs have helped dramatically slow the rate of growth in prescription drug spending, improve outcomes, and make coverage more affordable. In Medicare, for example, in 2014, the generic fill rate (GFR) for high blood pressure/heart disease class increased to 96.2%, while the GFR for depression treatments increased to 97.4%. The prevalence of generic drugs in Medicare has no doubt helped keep Part D premiums lower than originally forecast, reduced beneficiary cost sharing, and contributed to high beneficiary satisfaction.

In response to policymakers' consensus that projected biologic cost increases were untenable, Congress enacted the Biologics Price Competition and Innovation Act (BPCIA) of 2009. While the Food and Drug Administration has lagged behind the 27 other industrialized nations that have already brought biosimilars to market, biosimilars are poised to finally reach the US market. In March, the FDA approved the first US biosimilar, Novartis' Zarxio (filgrastim-sndz), to compete with Amgen's Neuopogen, which has been available since 1991. Amgen had filed suit to block Zarxio's market entry, but a recent Court decision may allow Zarxio to come to market as early as September 2nd. While the handful of biosimilars that are expected this year will not alone mitigate the marked increases in specialty trend, we do foresee discounts of about 20-30% compared to their reference product.

In anticipation of biosimilars coming to market, CMS and FDA face two critical issues that Congress should monitor closely: reimbursement and naming. With respect to reimbursement, CMS has asked that plans treat biosimilars as brand products for the purposes of reimbursement – yet these drugs will not quality for the manufacturer discount in the coverage gap. These drugs will have higher copays, like brand drug copays, but without the manufacturer discount, the remaining costs will be borne by the plan and CMS. Similarly, Express Scripts believes that identical naming between the reference product and its biosimilar is important to helping patients and clinicians recognize and utilize biosimilars.

As we reflect on the success of Medicare, Express Scripts is looking ahead to the next 50 years. We remain acutely focused on the challenges of high cost medications, an aging population, and the need to continuously innovate.

Express Scripts is proud to be part of this important American legacy, and believe our contributions to help keep medicine affordable will help ensure these programs celebrate more milestone anniversaries and are here for our children and grandchildren.

BJC HealthCare

Senate Special Committee on Aging

Field Hearing | July 31, 2015 | Five Star Senior Center, St. Louis, Missouri

Testimony Delivered by Sandra Van Trease – Group President, BJC HealthCare

Introduction

Members of the Committee, I thank you for the opportunity to speak before you today. My name is Sandra Van Trease, and I am a Group President for BJC HealthCare (BJC). BJC is one of the largest nonprofit health care organizations in the United States with 12 hospitals, multiple community health locations and some 26,000 employees. BJC delivers the full spectrum of health care services including inpatient and outpatient care, primary and critical care, community health and wellness, home health, behavioral health, rehabilitation, long-term care and hospice to residents primarily in the greater St. Louis, southern Illinois and mid-Missouri regions.

In my role, I am responsible for the BJC Medical Group, the BJC Accountable Care Organization, the BJC Collaborative – a consortium of six leading not-for-profit health systems in Missouri and Illinois – and several of our community hospitals. My comments before the committee will be focused on BJC's journey toward accountable care, what makes the BJC ACO unique and how we have impacted the senior populations we serve. I will also discuss some of the challenges we have faced along our journey toward providing the best possible care to our seniors.

BJC's Journey toward Accountable Care

In July 2012 BJC became the first health care provider in the St. Louis area, and one of only 89 in the country, to take on the challenge of forming an accountable care organization to take better care of seniors by participating in the Medicare Shared Savings Program (MSSP). Our current three-and-a-half year contract with CMS includes no downside risk and allows for equal savings between CMS and the BJC if we reach the necessary targets. When our current contract expires on December 31st of this year, we will be applying for Track III which will hold us to a higher level of accountability for our patients.

BJC's efforts over the past several years have focused on establishing the framework needed to better manage the care of our patients and the costs associated with their health care to help move us toward accepting additional risk for our patients and the cost of their care. In BJC's view, improving the quality of patient care and lowering health care costs can only be achieved through better collaboration between patients, physicians, health care providers and hospitals. The ACO has given us a platform to develop and accelerate these objectives by focusing on complex care management, transitional care management post-discharge and social work support.

The BJC ACO includes 10 BJC hospitals, BJC home health, three BJC long-term care facilities and the BJC Medical Group along with 200 independent community physicians, both primary

care and specialty. Our ACO is unique in that it is one of the few ACOs nationally that not only utilizes home care as a service provider but also places it within the ACO's governing body. The close integration of home care within our ACO is essential to our efforts to keep patients out of the hospital and lower health care costs as a result. Together, over 500 physicians across 23 specialties serve the roughly 39,000 Medicare beneficiaries currently attributed to the BJC ACO. Just over half of our beneficiaries live in urban and suburban areas including St. Louis City and County (34 percent) and St. Charles County (17 percent). The remainder of our Missouri beneficiaries resides in more rural areas in and around St. Francois County near Farmington (6 percent), Franklin and Crawford Counties near Sullivan (4 percent) and Boone County in Columbia (6 percent). Our Illinois beneficiaries are located in Madison County and its surrounding areas (19 percent).

Over the past several years as the ACO developed, BJC has initiated many projects to better coordinate care, improve population health and lower costs. Of particular note, we achieved National Committee for Quality Assurance (NCQA) Level III Patient-Centered Medical Home (PCMH) accreditation for all 43 BJC Medical Group primary care practices. Our journey toward PCMH accreditation allowed our practices to develop enhanced capabilities around patient access, patient education and record sharing, referral tracking, follow-up and care coordination.

Throughout BJC's accountable care journey, we have learned several key lessons that I would like to share with the Committee. Overall, we have tried to move away from unnecessary variation and instead focus on gaining efficiencies by better standardizing work flows and operations. In regards to physician operations, we found that it was essential to establish a centralized call center for our patients. We also extended the availability of physician office hours and increased our focus on year-long care planning with our patients. In regards to clinical data integration and data mining, we have learned the importance of sharing physician notes between providers as well as ensuring that the patients' data follows them in a single chart. In addition, we analyze data trends to risk-stratify patients and better align our resources to the patients that are most in need of assistance.

Thinking about lessons learned in care management, a cornerstone of our ACO model, we have embedded care managers that provide focused support for high-risk patients and monitor gaps in care. These care managers assist our patients in scheduling visits with their primary care physicians, medication adherence and reconciliation, and post-discharge follow up. While we continue to work to enhance our management capabilities, our early data suggests that this approach is effective. For example, within our Transitional Care Program, between March and June of 2014, our care management team contacted 96 percent of our patients (787 out of 817) within 48 hours of discharge from the ED or hospital. Of those patients that were contacted, 64 percent (502 out of 787) had appointments scheduled within seven days. This type of consistent, timely contact with patients, particularly those considered high-risk, is essential in maintaining the health of our seniors.

While the BJC ACO has made significant strides in improving the health of our patients, we have not yet reached the target necessary to achieve shared savings. We have, however, excelled in our quality performance scores. These scores are based on 33 quality of care metrics ranging from nationally recognized standards for heart disease and diabetes treatment all the way to the availability of physicians to see their patients and the overall patient care experience. For example, according to the preliminary[1] patient satisfaction results from 2014, 83% of BJC ACO beneficiaries are satisfied or very satisfied with how their physician is communicating with them. In addition, 63% of BJC ACO beneficiaries are satisfied or very satisfied with their ability to access specialists.

The Impact of the BJC ACO on the Senior Population

The ACO's expanded focus on care coordination benefits our patients because it enables the patient and his or her physician to share information and to sit down and have a very robust conversation about the care needs of that patient. Together, the patient and physician develop an individualized care plan that addresses the unique needs of the patient related to his or her health status. As part of this, we educate our patients about ways to better manage their health as well as how to identify the warning signs associated with their unique health conditions and to "call us first" when they experience these issues rather than going to the Emergency Department. This type of approach is particularly important and effective for patients with chronic conditions.

To better illustrate the impact of the BJC ACO, I would like to tell you about Ms. X, one of our seniors participating in the ACO. In April of this year, Ms. X was admitted to the hospital for an ischemic bowl perforation and peritonitis later followed by a multitude of other health issues including renal failure. For the next three months, she spent a total of 38 days in the hospital and 10 days in rehabilitation. Our team identified several challenges that were exacerbating Ms. X's situation and increased her risk of readmission, including a lack of transportation, lack of family support and that she lived a far distance from her primary care physician's office. With the assistance of a staff social worker who helped her identify her particular warning signs and what do to when she experiences them, Ms. X is now doing well at home and has not visited the Emergency Department or been readmitted to the hospital since June.

Another ACO patient, Mr. X, had been hospitalized for a series of abdominal issues which ultimately required surgery. Upon discharge, he was given instructions on how to care for his wound and perform daily self-injections at home. When a member of our ACO staff called Mr. X on his first night back at home, he was frantically trying to arrange all of his medications and had concerns about self-administering the injection. Although a home health visit was arranged for the next day, he was very anxious on this first night home. Our staff talked through the care plan with Mr. X and pointed out that his discharge instructions advised that he "stop taking these medications" for his usual prescriptions which he had not noticed. Mr. X was very reassured by

[1] Final data is expected in mid-September 2015

this call and felt that he could manage his care for the evening. Not only was Mr. X satisfied, but his care was provided and he avoided a potential readmission to the hospital as well.

Challenges We Face

Although we have made significant progress on behalf of our patients through the ACO, there are several challenges we continue to face in our efforts to provide the best possible care. While we have personally visited with CMS leadership to discuss some of our concerns, we wanted to relay a few challenges to you today which align around issues including reimbursement and current rules and regulations.

Our first area of concern with regards to reimbursement is related to home care services. Currently Medicare requires patients to qualify for "homebound" status in order for health care providers to receive reimbursement for services rendered by a home health nurse. In order to be considered "homebound," the patient must have a face to face visit with a physician so that they can provide documentation that 1) the patient is unable to leave home without "considerable and taxing effort" and 2) the patient has a "skilled need" that requires the skills of a licensed nurse, speech therapist or physical therapist to perform. Not only is this process arduous for health care providers who are seeking to provide the most appropriate care to the patient, at the right time and in the right setting – particularly for patients who were recently discharged from the hospital – but it is also a burden on the patients. Although BJC does not refuse home care services to our patients who have not yet received the "homebound" designation, it is important to note that we are not reimbursed for our services until that status is achieved. Our experience has taught us that it is vital to provide a home health visit as soon as possible after discharge in order to avoid a potentially unnecessary – and costly – visit to the Emergency Department. We respectfully request a review of this regulation.

In addition to the challenges we have faced with the designation of "homebound status," we have also encountered challenges with regards to the reimbursement of care management services provided by community-based service organizations. These organizations provide direct benefits to our seniors including transportation services and health management classes. Currently, these services are not reimbursed by Medicare which creates a significant burden for seniors with limited discretionary income. In order to help improve and maintain the health status of our seniors, we would respectfully request that Medicare consider reimbursement for the care management services provided by these community-based organizations.

Third, despite recent technological advances, reimbursement for telehealth has become a challenge as well. While telehealth offers many benefits to our seniors including increasing access to specialists by alleviating some of the burdens associated with transportation, we are not yet utilizing this tool to its full potential due to challenges associated with reimbursement. We would respectfully ask that Medicare consider developing waivers that specify when and under what circumstances telehealth services may be reimbursed.

Finally, the three-day inpatient rule for skilled nursing facilities (SNFs) has made it difficult for us to partner directly with local SNFs to the benefit of our patients. While we applaud Medicare's decision to approve a waiver to remedy this in 2017, these challenges will remain for the next year and a half until the waiver goes into effect.

Objectives – What we hope to achieve on behalf of the patients and families we serve

Overall, the goal of the BJC ACO is to provide our seniors with high-quality service and care at the right time and in the right setting. When the BJC ACO is successful, our patients will experience better health, our community will have better health care and we will be providing better value.

Conclusion

In closing, I want to thank the Committee for the opportunity to speak before you today. I would be happy to answer any questions you may have. Thank you.

National Committee to Preserve Social Security & Medicare™
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Testimony of Max Richtman, President and CEO
National Committee to Preserve Social Security and Medicare

United States Senate Special Committee on Aging
Hearing on "Celebrating Medicare: Strengthening the Program For the Next 50 Years"
St. Louis, Missouri
July 31, 2015

My name is Max Richtman, and I am the President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare in Washington, DC. The National Committee is a grassroots advocacy and education organization dedicated to preserving and strengthening safety net programs, including Social Security, Medicare and Medicaid.

In my current position and as a former staff director of the Senate Special Committee on Aging, I especially appreciate the opportunity to testify today as we celebrate the 50th anniversary of the Medicare program. I commend Senator Claire McCaskill, Ranking Member of the Aging Committee, for holding this field hearing on strengthening Medicare for the next 50 years. I must also add that I appreciate Aging Committee Chair Susan Collins's leadership on issues critical to older Americans and I have enjoyed working with her and Senator McCaskill. The Senate Aging Committee has a long history of highlighting the importance of the Medicare program for beneficiaries and their families and of working to improve and strengthen Medicare for current and future recipients.

Medicare's Success

Yesterday we celebrated the 50th anniversary of the day Medicare - one of our nation's most popular and successful programs - was signed into law by President Lyndon Johnson. Before the enactment of Medicare in 1965, only 50 percent of seniors had health insurance and 35 percent lived in poverty. That was a time when even a minor illness or injury could bankrupt older Americans and their families. Fast forward to 2015 when over 55.3 million Americans are receiving guaranteed health care benefits through the Medicare program regardless of their medical condition or income. This includes 46.3 million Americans age 65 and above and 9 million Americans receiving Social Security disability insurance benefits. By the time the last of the baby boomers reaches age 65, it is expected that close to 80 million people will be covered through Medicare. Together with Social Security and Medicaid, Medicare forms the bedrock of economic security and health security for today's seniors and for tomorrow's retirees as well as for individuals who become disabled.

Minding the Gaps in Medicare Coverage

Medicare goes a long way in preventing poverty and promoting greater access to health care for people 65 years of age and older and people with disabilities. However, Medicare coverage is not comprehensive. In addition to Medicare's cost-sharing – for premiums, deductibles and coinsurance – Medicare beneficiaries must pay out of pocket for gaps in Medicare coverage. The standard Medicare benefit does not cover hearing, dental and vision care and most long-term services and supports. These coverage gaps often come as a surprise to beneficiaries when they

need these services, and they are a great financial burden or unaffordable for many people. In 2013, Medicare households spent three times more than the average household on out-of-pocket health care costs even though half of all Medicare beneficiaries had incomes below $23,500. Older Americans should not have to choose between paying for health care, food or utilities. Medicare benefits must be improved, not cut, and Medicare's long-term solvency must be strengthened.

In its 50 year history, Medicare has demonstrated that it is a dynamic program, meeting the changing demographic and health security needs of older Americans. Starting in 1966, Medicare provided only hospital and outpatient coverage, through Medicare Part A and B, and only to people 65 and older. In 1972, coverage was added for individuals with disabilities and end-stage renal disease. Starting in 1982, Medicare provided coverage for hospice care, a prescription drug benefit was added in 2003 and mental health benefits were significantly improved in 2008. And the Affordable Care Act, passed in 2010, includes many Medicare improvements to promote better health and save money.

Medicare is now delivered in many forms, through traditional Medicare, administered by the federal government, and also through private health plans. These include Part D prescription drug plans and Part C Medicare Advantage plans, which cover Part A, Part B, and sometimes Part D benefits as well as some optional supplemental benefits. In addition, most Medicare beneficiaries have the option of purchasing supplemental coverage, through Medigap plans, to wrap around their traditional Medicare benefits, covering standard cost sharing for health care services.

The Affordable Care Act Strengthens Medicare

Medicare's future and benefits were strengthened by the Affordable Care Act (ACA). It improves care for Medicare beneficiaries by eliminating out-of-pocket costs for preventive screenings, annual wellness visits and personalized prevention plans; providing discounts on prescription drugs in the Part D coverage gap known as the "donut hole," which will be phased out by 2020; and providing incentives to improve the quality of care. The ACA strengthens Medicare's financing by reducing waste, fraud and abuse; slowing the rate of increase in payments to providers; and phasing out overpayments to private Medicare Advantage plans. Projections of the solvency of the Part A Trust Fund have increased by 13 years since passage of the ACA. There's a lot to celebrate about Medicare's past, and thanks to the Affordable Care Act, a more hopeful outlook for the present and future.

Improving Medicare's Payment and Delivery Systems

The National Committee to Preserve Social Security and Medicare's Legislative Agenda for the 114th Congress includes several proposals for strengthening the Medicare program and enhancing benefits. One of our priorities is strengthening traditional Medicare by building on the Affordable Care Act's payment and delivery system reforms that are containing costs and promoting high-quality care. Accountable care organizations, medical homes, bundled payments and value-based purchasing are improving and coordinating care for beneficiaries with multiple chronic conditions and reducing costs. In part because of the savings in the ACA, the growth in Medicare spending per enrollee has slowed significantly in recent years. Spending per enrollee

in 2015 will be about $1,200 lower than was projected in 2010 (Source: The Facts on Medicare Spending and Financing).

Expanding Medicare Benefits

The National Committee's legislative agenda includes many proposals to improve current Medicare benefits. These include enacting a catastrophic out-of-pocket limit for spending in traditional Medicare; counting all observation days in the hospital toward meeting the three-day rule to be eligible for Medicare's skilled nursing facility (SNF) benefit; and expanding Medicare benefits to cover vision, dental and hearing health services which are important for healthy aging and are often unaffordable for beneficiaries.

Recently, I participated in a press conference to promote H.R. 1653, the "Medicare Hearing Aid Coverage Act," legislation introduced by Congresswoman Debbie Dingell to expand coverage in the Medicare program to include hearing assessments and hearing aids. I can't think of a better time than the 50th anniversary of the Medicare program to get the expansion movement rolling, and Representative Dingell's bill is a solid first step. Passage of this legislation would mean that millions of seniors with hearing loss could finally get the help they need to pay for assessments and treatments.

The National Committee Foundation has published an issue brief "The Case for Expanding Medicare Hearing Loss: The Economic, Social and Medical Factors Impacting Healthy Aging" to demonstrate why Medicare should cover hearing aids which can range anywhere from $3000 -

$7000. Many older Americans on modest, fixed incomes simply cannot afford to pay out of pocket for their hearing, vision and dental care. They go without needed treatments. In the case of hearing loss, this means that safety risks are increased because they can't hear a car coming or can't hear the phone ringing or an alarm going off. They can't clearly hear the instructions from their doctor during a check-up which could lead to mistakes in taking their medications. They can't hear – so they get confused, embarrassed or frustrated, and they gradually withdraw from their normal routine of activities. This isolation may be linked to the early onset of dementia or Alzheimer's disease. If hearing aid coverage could slow the onset of these dreaded neurologic diseases, billions of dollars in Medicare and Medicaid spending could be saved. That's why the Congress should enact Representative Dingell's bill and consider other proposals to improve Medicare benefits.

Proposals to Make Benefit Improvements Affordable

Enactment of the Affordable Care Act is the most recent example of how lawmakers paid for and expanded Medicare benefits. Today, there are several proposals available to offset the cost of expanding Medicare benefits that we have included in the National Committee's legislative agenda. We support savings from restoring the pharmaceutical drug company rebates for medicines prescribed to dual-eligibles, those on both Medicare and Medicaid, which could generate $121 billion over ten years. Additional savings could come from allowing the government to negotiate Part D prescription drug prices, accelerating the closure of the Part D coverage gap (donut hole), stopping pay-for-delay agreements that keep less expensive generic drugs off the market, promoting faster development of generic biologic drugs, completely

aligning Medicare Advantage (MA) and traditional Medicare payments and halting the practice of "upcoding" that some MA plans engage in to receive higher payments.

Conclusion

Medicare has provided five decades of quality health care to seniors and people with disabilities and lifted generations of Americans out of poverty. It has accomplished this at a cost consistent with or lower than the increase in private health insurance premiums. Medicare's success has made the program tremendously popular. Across party lines and all age groups, large majorities support our efforts to protect and improve Medicare benefits for all Americans.

Since 1965, Congress has gradually erased some of Medicare's coverage gaps, but more must be done to make benefits comprehensive and health care delivery more efficient without compromising the quality or accessibility of care.

We urge Congress to focus on improving Medicare with a new sense of urgency because the program – when combined with Social Security – has become increasingly important to the economic security of millions of retirees. That's because stagnant wages are grinding away at the middle class's ability to save for retirement. And, many employers have significantly scaled back or eliminated the retirement benefits offered to their employees. As a result, current and future retirees cannot afford proposals to cut benefits, raise the eligibility age or privatize the program.

Instead, now is the time, on the 50th anniversary of Medicare, to build on the program's successes in keeping older Americans healthy and out of the poor house, while also containing costs for seniors and the program itself, by supporting proposals to expand benefits so that Medicare provides comprehensive and affordable health care coverage.

Thank you again for the opportunity to share the National Committee's views on the future of Medicare.

TESTIMONY BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

"Celebrating Medicare: Strengthening The Program For The Next 50 Years"

Friday, July 31, 2015

Five Star Senior Center - 2832 Arsenal Street, St. Louis, MO

Mr. Ron Sergent
AARP Missouri

For further information, contact:
Ariel Gonzalez
Director, Federal Health and Family
AARP Government Affairs
(202) 434-3770

Chairman Collins, Ranking Member McCaskill, and members of the Committee, thank you for holding this hearing to celebrate Medicare and look towards its future. My name is Ron Sergent, and I am a former AARP Executive Council member and a volunteer here in Missouri.

As we commemorate Medicare's 50th Anniversary, it is essential that we not only celebrate what it's meant to so many people, but we must also be honest about what Medicare means today – what it covers and what it doesn't cover. We must recommit ourselves to keep this vital lifeline strong for current and future generations.

From the beginning, AARP's founder, Dr. Ethel Percy Andrus supported the creation of a federal health insurance program for *all* older Americans tied to Social Security – the essence of what became Medicare.

Back in 1965, three out of four Americans *under* age 65 had adequate private hospital insurance – but only about one in four Americans *over* age 65 were as fortunate. If you were an older person, getting sick meant you risked losing not only your health, but your financial independence.

Today, fifty years later, Medicare provides guaranteed, affordable coverage for roughly 45 million Americans 65 and older and about 9 million people with disabilities. Medicare is largely responsible for the poverty rate among older Americans dropping to less than one of every ten.

The program has transformed the lives of millions by helping them to pay for many vital health care services including hospitalizations, physician visits, and prescription drugs. And, most recently, essential preventive services have been added to Medicare by the Affordable Care Act.

While the program offers important benefits, Medicare is NOT a "free ride. It is not a Cadillac plan. More like a reliable Chevy.

There are premiums, deductibles and co-pays which people have to pay for. And there's a lot that Medicare simply doesn't cover.

It *does not* cover the cost of care for dental, vision, or hearing problems. The need for eyeglasses and hearing aids is particularly common among older people. Moreover, Medicare does NOT cover long-term nursing home care.

It is important to remember that half of all Medicare beneficiaries live on incomes of less than $23,500 per year. Beneficiaries pay an average of about $4,500 each year out of their own pockets for cost-sharing and services not covered by Medicare. For the typical beneficiary, this amounts to over 17 percent of their income.

Medicare's golden anniversary is a time to think ahead about how we can ensure that the program continues to fulfill its essential role.

Medicare today faces a number of challenges, including the rising cost of health care and a growing aging population. Some say the answer to these challenges is simply to cut benefits or force seniors to pay more. AARP believes there's a better way. There are responsible solutions that will stabilize the system.

We can start to put Medicare on stable ground by clamping down on drug companies' high prices; improving coordination of care; and using technology to make care more accessible and efficient.

Looking forward, we must recognize that the way people receive care is changing. For instance, more people are receiving care from non-physician providers, and are using telemedicine to access care more conveniently.

Additionally, almost 9 in 10 seniors say they want to remain in their home as they age. We should do everything we can to let that happen. Aging in place helps maintain a better quality of life and is less costly than institutional settings. This means funding community based services, such as meals on wheels, which help older Americans live independently. It also means supporting family caregivers through tax policies and workplace programs which recognize the economic contribution made by individuals taking care of loved ones.

AARP stands ready to help keep Medicare strong for the next 50 years. Thank you for the invitation to testify today. I'm happy to answer any questions.

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