“Inside Deficit Reduction: What it Means for Medicare”

Alliance for Health Reform
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ED HOWARD: – will materialize before your eyes in just a couple of minutes. My name is Ed Howard. I'm with the Alliance for Health Reform. And on behalf of the Alliance and the Alliance Board and Senator Rockefeller, I want to welcome you to this second in a four part series of briefings on the deficit reduction work now underway in Congress. Today we're going to focus on the Medicare program.

Now if Willie Sutton were chairing the super committee, you know that he'd have somebody casing the Medicare program because it accounts for more than one dollar in seven of the entire federal budget. And it accounts for one dollar in five, even a little more, of total health spending in this country.

So, today we're going to look at some of the program changes that have been made in the past. What some of the more prominent proposals for change are on the table today and what the impact might be if they're adopted both on the federal budget and on healthcare spending in general. And I guess maybe we don't want to lose sight of this part of it; what the impact is going to be on the 48 million Americans and their families who depend on Medicare to be able to afford the healthcare they need.

Chairman Sutton might not have cared about all those factors but I think the people on this panel will. And I think most of us do.

Now in the first briefing in this series, as we are going to do today, we're changing a few things in our normal M.O. We have two distinct panels, not one, with Q&A opportunities after each. And we'll try to squeeze all that into just an extra 15 minutes. So we're going to run to 2:15 instead of 2:00 p.m. as is the norm.

And, let me just review the bidding. This is, as I say, the second of four deficit reduction briefings the Alliance has planned. After this one focusing on the implications for Medicare, we'll hold one on the implications for Medicaid in November. And then in early December, once the deadline for action by the super committee's past, we'll take stock in a final briefing.

And I need to do a shout out for our co-sponsors for this series. It's a bit unusual for us as well in this instance; we have four co-sponsors for all four briefings. The Robert Wood Johnson Foundation, The SCAN Foundation, the Kaiser Family Foundation and The Commonwealth Fund are all co-sponsoring all four deficit reduction briefings. And you'll find a bit of background information on all of them in the sheet in your kits. And I urge you to take a look at it. And I want to thank each of those co-sponsors for being willing to take part in this multi part exercise.

And I particularly want to thank one of them, The Commonwealth Fund, for providing us with our co-moderator today, Karen Davis, who's The Fund's president and CEO. If you've read

the biographical notes in your packets, you know that Karen's been in key positions in academia and in government for many years. And has probably forgotten more about Medicare than most of us will ever know. Now, actually that's just a figure of speech. It's very unlikely Karen has forgotten anything about Medicare. And so let me turn to the expert as a co-moderator, Karen Davis.

KAREN DAVIS: Thank you Ed and thank you for sponsoring this series of briefings. We can tell from the turnout that this is an issue that is on everybody's minds. And so we're fortunate to have such a great set of speakers.

Just to set it up, I'm using the traditional Congressional Budget Office chart on revenues and government expenditures as a percent of the gross domestic product. I prefer to think only out to 2035. But even on that timeframe, two things are clear to me from this chart. If you – if we look at our current situation, revenues are the lowest they've been as a percent of GDP and expenditures are the highest that they've been. In fact if this chart went back as far as 1950, revenues as a percent of GDP are the lowest that they've been in 60 years. So that's part of the problem. But also expenditures are the highest.

If we go out to 2035, Social Security, Medicare, Medicaid, subsidies for those receiving the health insurance through state health insurance exchanges will consume virtually all of federal revenues leaving no room in the federal budget for anything other than healthcare. So it's not surprising that the health programs

particularly Medicare and Medicaid are coming in for a fair amount of scrutiny on what can be done to bring more savings out of the federal budget.

The very interesting article in your packet by Michael Chernew called “How Much Savings Can We Wring from Medicare?” And he explains that the rate of growth in Medicare spending relative to the rate of growth in GDP per capita used to run at over two percentage points a year. In the 1980s, 1990s, it was running about 1 1/2-percent faster than the growth in GDP per capita. But what he notes in our current decade is that Medicare is projected to rise at least about a half a percentage point less than the rise in GDP per capita.

And that's two things. Both at in the baseline, we have the sustainable growth rate formula determining what physicians are paid that would mean major reductions in physician fees. And that slows down Medicare spending. Plus the savings that are in the Affordable Care Act in the Medicare Program, the productivity improvement, the reductions in payment in Medicare Advantage another.

So we are already, if we think in terms of baseline, at below GDP growth for the next decade. And Chernew's point in the article is we're going to need a lot of policy solutions just to achieve what is already on the books without achieving more savings to contribute to the overall deficit solution. And the next decade is not much better. We have only about a percent point in the

baseline growth above the rate of growth in GDP, effectively the formula that was given to the independent payment advisory board as their target for slowing Medicare spending.

But I do want to stress that this is not a Medicare or a Medicare and Medicaid problem but really a total health system problem. If we look at the trends – projected trends in Medicare outlays per person compared with private outlays per person, if anything, private outlays are going up much more rapidly than Medicare outlays. And it doesn't really work to squeeze down on one part of the health system. You both get ineffective cost controls and you get undesirable distributional effects.

That's particularly a concern because Medicare and even more so Medicaid cover very vulnerable populations. Half of Medicare beneficiaries have incomes below twice the poverty level. Half have some form of chronic condition. Over a fourth have some cognitive or mental health impairment. Many of the highest cost Medicare beneficiaries are frail or disabled.

There isn't much room to increase what beneficiaries pay on their own. Shifting costs from the federal budget to beneficiaries, beneficiaries already spend a high percent of their income on healthcare. About 16-percent in 2005; that's up from 12-percent in 1997. And for lower income beneficiaries, the half with incomes below twice the poverty level, they are already spending 22-percent of their income.

So what are the policy options for dealing with Medicare healthcare reform, the federal budget deficit? As an economist, they're pretty simple. It's quantity or price. But there are different ways of doing that. In terms of quantity, one can cover fewer people, for example, raising the age of eligibility of Medicare. One can cover fewer services or one can cover a smaller fraction of total spending or of premiums.

Or one could have a more sophisticated strategy that would restructure current out-of-pocket costs; current deductibles and co-insurance to shape better healthcare choices that's generally called value based insurance design. So even if you didn't have an increase in the overall level of beneficiary cost sharing, it could be targeted on discretionary services and you would achieve savings by reducing use of those services.

The second basic strategy, a price strategy, would be across the board cuts. That's something the Congressional Budget Office always scores as achieving saving, has been found to work. Or one could have selective cuts or overpriced services. And we see some of that in the recent MedPAC recommendations.

A more sophisticated strategy is trying to use purchasing leverage to get lower prices including multi-payer approaches to slow price growth. And I think we're just now beginning to learn a fair amount about some of the payoffs that is going on in terms of prices particularly in the private market.

The last is a combination price and quantity. And that's to reduce selectively misuse, overuse and underuse. That could be done by changing the delivery system, innovations like medical homes, accountable care organizations. It can be done by applying comparable effectiveness researched insurance benefit design or pricing. We can pay smarter moving away from fee for service toward bundle payments, value based purchasing that reward healthcare delivery systems whether those are medical homes, accountable care organizations with both achieving better quality and saving in total health spending. So that's a quite overview. And with that, I'll turn it back to Ed.

ED HOWARD: Great. Thank you, Karen. Excuse me. Let me just do a little housekeeping here. If you've been to our briefings, you probably have heard this before. But, just pay the attention that you give to the flight attendant when he or she reads the instructions for what happens when ditch over the ocean. There are a lot of background information in your packets including where we have them – the hard copies of the PowerPoint slides. And there are speaker biographies that are more extensive than they're going to get from us.

There'll be a webcast and a podcast available tomorrow on kff.org courtesy of the Kaiser Family Foundation. You'll find all of those background materials in electronic form on allhealth.org. That's our web site. In a couple of days also, on our web site, you can find a transcript of today's discussion. And in the next

day or two, there's going to be a good summary of the discussion on The Commonwealth Fund Blog which you can access at commonwealthfund.org.

So, as I mentioned, you're going to get a couple of bites at the Q&A apple this afternoon after each of the segments in the program. And at that time, those of you here, not watching the webcast, can fill out the green question cards or come to one of the microphones. There's one up front. There's one further toward the rear of the room. And we'd appreciate you filling out those blue evaluation forms in the packets so that we can make these programs even better for you.

Now, we have a terrific group of experts today as Karen alluded too. And in the first part of the program, we're going to try to give us a sense of how major changes in the program have come about in the past, how they've been carried out as well as a view of a couple of people who've run the program and have a lot of insight into how to improve it now.

And we're going to start with Tom Scully. He's the general partner with the private equity firm, Walsh — I'm sorry — Welsh, Carson, Anderson and Stowe as well as senior counsel at Alston & Bird here in Washington and as I mentioned, a former administrator of the Centers for Medicare and Medicaid Services. Tom, thanks for being with us and get us started if you was.

TOM SCULLY: And an old guy. So Ed asked me to go through my experience which goes back to, I think, 1864 or something like

that. [Laughter] But anyway, and unfortunately, I had to go to Houston yesterday so the dog ate my homework. So you're not going to get any pretty slides. Somewhere between Houston and here last night, they melted down. So you're going to have to look at Mark McClellan's nice, pretty slides. And you're just going to have to listen to my points.

As Karen said that you know the — all of this Medicare policy is always driven by deficits. And it's always driven by budget policies. And, if you didn't have budget deficits, you wouldn't have big Medicare changes. It's true of just about everything. And I'm going to run through a bunch of them.

But if you look at the deficit charts up there, you got 15-percent of revenues and 25-percent of spending. Something is definitely going to give whether it gives before the Presidential election or not. I would bet it's not. You can't have a 10-percent, 11-percent structural deficit. And you could argue revenue should be 20-percent and you should argue spending should be 20-percent. That's what I would argue. [Laughter] But yeah, it's not going to stick at 15-percent of revenues and 25-percent of GDPs as — in spending. It just can't be done.

So you know Republicans and I'm not going to get into this argument — would argue we don't want any more taxes. Till spending gets down to 20-percent of GDP then call me, we'll worry about revenues. And obviously Democrats are saying like we don't want to cut all these programs until revenue goes up. So, my guess is

given the current landscape, that's not going to change in the next year and a half no matter what I say.

So, but all these things are driven by deficit reduction facts. And all of these things have been around forever. And this isn't the first time. These are things look the same over and over. So if you look – if you watched the movie *Groundhog Day*, one of my favorites, this all seems to me like watching the movie, *Groundhog Day*. It's the same stuff. And the CBO budget charts are shockingly the same today as they were in 1982.

By the way, I should know from Karen's charts that when I had Stuart Guterman working for me, my charts looked pretty damned good too. [Laughter] So there's the fundamental difference in the – but the – but anyway, going back, I started working in the Senate in 1981 believe it or not. So when you go back and look at, you know, what drives these things. The 1982 budget deal gave you DRGs. You wouldn't have had DRGs otherwise. So everybody knows what DRGs are. I'm sure everybody's used to them now. There were no DRGs between 1982. And why did those happen? Because somebody needed some budget saving. And just like RBRVS, which I'm going to get into later, evolved from that. The Yale School of Public Health came up with DRGs. And it was tried out in a couple of states through New Jersey primarily. And after a few years of having no idea of whether the hell they're going to work or not, we put them in national because it saved a little money. That's just the way it works.

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There was tax reformers talking now about cutting rates and raising revenue. Magically if you went back and looked at the Rostenkowski, Bradley — whoever else was involved — Reagan tax deal of 1986 tax reforms, shockingly, revenues went up and we cut rates. So, you know the idea that that's a new concept is also not a new concept.

If you look at Gramm-Rudman, people talking about the sequestration. Grammm-Rudman passed in '85 was found to be unconstitutional and was passed in '87. And it created caps and pay as you go and all the things they're talking about, all the sequesters' rules you go back and go back to 1987. So there's nothing new about sequesters. That goes back to 1987.

1989 I went to the work in the Bush OMB in White House. And my first job was the lovely challenge of RBRVS now known as SGR. I think Tricia was involved in that if I remember. Maybe it was — it might have been before your time. But what happened then before I forget was physician spending was completely out of control. It was growing at 15-percent a year. We had a Democratic Congress. You know a very huge Democratic majority in Congress, a new Republican President. We wanted to control costs. And the Democrats said we'll put in these ratchets and automatic cuts if you can get half of the Republicans to vote for it.

So all the Democrats were for it in Congress. We got half the Republicans to vote for it over the violent objections of the AMA. And we put it, you know, value performance. RBRVS now called

SGR. It kicked in in 1992. People conveniently forget—I'm sure there's many, many people here—that it worked extremely well from 1992 to 1997.

Another budget lesson, in 1997 which I'll get to in a minute, everybody in healthcare got scorched. And there were cuts all across the board. The AMA came in and said we don't want to take cuts. We'll just tighten up the SGR—it was then called the RBRVS formula—a little bit. And we'll just tweak it. Well they took all the flexibility out of it. And the reason you have cliffs every year now ever since then is that everybody else took big cuts in '97 which I'm going to get to in a second. The AMA came in and said we don't want any cuts. We'll just tighten up our formula. And they created these cliffs year after year after year. So here we are 15 years later dealing with budget cliffs that drive lots of stuff.

By the way I didn't mention but when you look at that 10-percent of GDP deficit; that's the 10-percent of GDP that doesn't count the fact you got to fix the SGR by the end of the year. It assumes the Bush tax cuts expire which may not happen. And it doesn't assume $130 billion a year minimum of healthcare reform coming in in two years. So, the deficits are even bigger than they looked like but.

But anyways, so if you go back and look at the 1989, my first job was passing RBRVS. It wasn't controversial at the time.

It's now turned out to be the single biggest budget problem every year in Congress.

If you look at 1990, I was the budget summit guy for President Bush. Remember – if anybody here remembers reading my lips no new taxes. Sounds to me a little bit like this year. Republicans and President Bush got elected saying absolutely no way in hell I'm going to raise taxes. We had what was then considered to be a $350 to $370 billion budget deficit when those days was massive, a very Democratic Congress and President Bush decided to compromise.

So you're saying a lot of people on the Democratic said to the Republicans why don't you compromise and raise taxes. Most Republicans will say I remember George Bush still, he got killed for saying he wasn't going to raise taxes and raise taxes.

So, politically it's not easy. So we went out and spent – it didn't actually happen there. We spent about two weeks at Andrews Air Force Base in 1990 hooking up all kinds of crazy policies to reduce the deficit. I just thought of a few that some of you may still love.

I remember sitting on a bed at Andrews Air Force Base when we needed $3 billion. And I said to John Sununu who was in the White House—chief of staff—all these policies stink. This is a common theme among staffers. But then-Senator Pryor, Chris Jennings, some of you may know, has this really stupid idea to do

Medicaid drug rebates. Why don't we take that and blame it on him? So that's how you got Medicaid drug rebates.

For those of you who love Medicaid drug rebates, we needed $3 billion and we can blame it on then-Senator Pryor. And we stuck it in the 1990 budget deal. So most people don't remember that history but what drove that? Had there not been a budget deficit, a 1990 budget deal, you can debate the merits of Medicare drug — Medicaid drug rebates and whether they should be added to Medicare. But they were driven 100-percent by the deficit. And it was done in the middle of the night at Andrews Air Force Base because we had a lot of really bad ideas. And that was the least bad idea which is the way most of these things are done.

If you look at other things that happened out there, people in the hospital business think, you know, hospital cuts market basket reductions have never happened. We did market basket minus two for six years I believe is the last I can remember back. And so, most of the '90s, we had a market basket minus two for most of the providers. And magically they all seem to have survived that.

If you look at DSH and IGT for those of you who follow Medicaid, big fights, one of the biggest fights in '92 was limiting state use of DSH and IGT which that — the balloon in that area is still being pushed around many years later. But none of that is new.

So when you look at it, the issues in the 1990 budget deal where we basically did a $500 billion of deficit reduction for five

years. It lists the CBO budget cuts, the list of analyst cuts. The list of things you're looking at, it's the same list. When you go back and look through the MedPAC list and other lists, it's the same lists as we were looking at in 1990. Very little has changed.

So if you move on and see what's in 1995 when Gingrich and those guys passed the Contract with America. They came in and what were they going to do; big budget deficit cuts. That was the whole fight and Medicare cuts. It got vetoed — didn't happen.

In 1997, after President Clinton got reelected and I think this is a model for what's going to happen in 2012, a newly re-elected President on the Democratic side with a very Republican Congress which very likely could happen in reverse next year. Not going to care as much about the — he's going to be hit with a big deficit. They did a giant deficit reduction bill built around Medicare cuts.

The 1997 deficit reduction bill was massive. Now you could argue it was good or — whether it was good policy or not. But, and some things probably were done that needed to be done. But the home health industry cratered. Maybe they should have. There was an argument back then that every living person in Louisiana actually owned a home health agency. [Laughter] But it did go from $3 billion in 1991 to $18 billion in 1997 year in spending and back to $10 billion the next year. Well that happens. [Laughter] You get big corrections that are ugly.

Two thirds of the nursing home chains in the country went into bankruptcy in 1998. Now you could argue in 1996 and '97 bad stuff was going on but over corrections are also a lesson. If you look back from 1997 to 1993, we had give back bills for five years. All the hospitals, all the SNFs, all the home health agencies; the corrections were too much. You lost lots of providers and there was lots of give back bills.

So you know cuts can happen. Market basket minus two can happen. But radical cuts don't last for very long because the system can't sustain them. And while the 1997 budget deal set us on track by raising revenues and reducing spending for budget surpluses for a number of years and arguably was directionally right, I think if you went back and looked at it almost everything in Medicare was probably a little too harsh. And we ended up giving a lot of money back in dribs and drabs and doing correction bills for five years.

So, I think if you're looking for an impression of what's likely to happen next year, I would say 1997 is it. I personally know [inaudible] through the election. I think if you were betting, who knows about a month ago I would have bet more money that President Obama get reelected but there's certainly still a good chance.

And there's a good chance you'll have a very conservative Republican Congress. And they're going to have a massive deficit. And they're going to have to do everything but the kitchen sink.

They're going to have to not raise taxes but raise revenues. They're going to have to cut Medicare. They're going to have to cut Medicaid. They're going to throw everything you're going to think of because this deficit is massive and getting bigger. And there is no easy way out. And the list of the same and the hole's bigger and the policies are tougher. So there's no easy way to get around it.

So then if you can look back at the things I did and by the way, I would say for the six years at the end of the '90s, I was President of the Federation of American Hospitals. So I ran a hospital association and lived through these cuts. And magically we all survived them.

So you look back at 2001 to 2003, at the time, we had huge surpluses. We had a bidding war with Democrats over who could spend more in prescription drugs. I take a lot of shots now for how could you have not financed that thing. Well at the time, we had a big tax cut which people forget in 2001. And we still projected big surpluses. And Democrats were trying to spend a trillion dollars or more over 10 years on drugs. And the cheap Republicans only want to spend $400 billion. So we spent $400 billion. I still think the bill was the right thing to do. I spent most of my – a big part of my three years on it. We didn't deficit finance it because we projected giant surpluses.

The point of that is had we known where we were going to be today that bill never would have passed. It would never had a

chance. It never would have had a prayer. Because looking at where you are today in deficits, you went back and said knowing what you would be in 2011, would you have done that in 2003. We would never have gotten any of the votes. It would never even come up. It never would have been done. So it all depends on the circumstances you're in.

Now the reason I throw that in is I think among Republicans and maybe the market and it may be the last two moderate Republicans in the universe. Is that true? [Laughter] I'm pretty moderate. And I personally was not a big opponent of the structure of the — of the — President Obama's plan. I was a fairly strong opponent of the size. I think the benefits are too big. I think the spending is too big too fast.

But the structure is very similar to one of the things that I had advocated for years, it's the mass that you put on top that was too big. But the point is with the $1.2 billion — trillion deficit, you're going to have to throw everything in the kitchen sink in a couple years to solve this. And this is a massive slug of money coming through in 2014. 22 million new people on Medicaid, 20 million new people with subsidies; whether you agree with the structure or not with your financial coverage which I have been for many, many years, it's a hell of a lot of money in the current economics to push through the system that really doesn't have the financing in sight to see.

So, what does that mean for me just from the lesson learned? We wouldn't have done the Medicare drug then if we knew we were. Nobody ever would have conceived that we'd had a trillion dollar a year budget deficit. Looking at this in 2014 and saying we got a $1.2 trillion budget deficit, it's probably bigger than that. Is this the right time to do this amount of spending?

You know the President's not going to budge on it because it's a signature issue. Republicans want to repeal, repeal, repeal. I remind some of my Republican friends you need 60 senators to repeal something. There's never been 60 Republican senators in the history of the republic. That ain't going to happen.

What's a reasonable option that's dealing with reality after the next election? Probably delay because the money ain't there to do this. That doesn't mean it's not the right policy. It just means maybe it'll be scaled back a little bit. And maybe you should make sure the deficit's below — pick a number — 3-percent of GDP or 4-percent of GDP before you take on a massive entitlement expansion.

But I think these are the things we'll really be talking about in a year and a half. We may get a little bill. I personally think it's very unlikely and tough to see how they do something before the end of the year given the fact that they have an easy exit with the sequester.

But what are you looking at next year? Lower tax rates and magically you're going to get higher revenues. Shocking. You can cut rates and raise revenues. Big Medicare cuts; I hope they don't make the same mistakes made in '97 and go too far. But you're going to get big Medicare cuts. You're probably going to have to raise the retirement age to 67 over 24 years. We've been doing that for years in Social Security. Believe it or not, nobody seems to have noticed. Why that's such as incredibly tough political issue for me I don't quite get.

And the biggest issue which nobody wants to talk about is I would bet when you really look at the numbers, the single biggest moving piece in the federal budget that's doable is to delay the onset of health reform by two years, three years, whatever. Say look if your choice is cutting benefits to existing Medicaid beneficiaries and existing Medicare beneficiaries or raising taxes, as long as I've been doing this, it's much easier to defer promised benefits to somebody who hasn't gotten them yet than to just to cut benefits for people that have them.

And I – if President Obama's [inaudible] and I've talked to Republican leaders, they don't repeal, repeal, repeal. We're not going to talk about that. The reality is when you get around in a year to this I think that's where you're going to be. So the lesson's I would just say before I dive in here with Mark is you're going to get a lot of triggers and I think if I had to bet in a couple years you'll say we can only do health reform if we have a

trigger that the deficit's below X percent. That's when we'll turn on the spigot for the Medicaid expansions and the Medicare expansions. Easy way to save money and move the numbers and you're going to get a lot more capitation.

If you look at one other thing, I'll just wrap up with, is the states figured out, whether you're Democratic Republican or the Democratic governor or Republican governor magically managed care in capitation isn't such a bad idea because it works. It saves money. It lowers your costs and it drives much better behavior to have somebody at risk outside of the state treasury.

We're going the same direction. You can call it bundling. As I always say, we ought to do pre-acute bundling and post acute bundling and then acute bundling. And then bundle them all together, call it private insurance and get the hell out of dodge. [Laughter] That's where we're going in my opinion in the long run. And it's all driven by the budget because that's what makes economic sense. Thanks.

ED HOWARD: Okay. Thank you Tom. Do you want to pass that down to —? And as promised as part of our just in time inventory program, Mark McClellan has joined us. He's the Director of the Engelberg Center for Healthcare Reform at the Brookings Institution and as noted, a former administrator of the Centers for Medicare and Medicaid Services. We didn't note that he is also a board member of the Alliance for Health Reform for which we are very grateful.

Tom's — or Mark's slides didn't make it into the packets. They will be posted on our Web site later this afternoon. Mark thanks for being here. And it's all yours.

MARK MCCLELLAN: Great Ed, thanks very much and sorry to be late. Looks like I missed a good lunch and also the first few minutes of Tom's remarks. So you heard it here first, right, President Obama reelected —

TOM SCULLY: No. No. [Interposing]

MARK MCCLELLAN: — to preside over delay and the implementation of his healthcare reform [inaudible]. [Laughter] That was good. So —

TOM SCULLY: It's amazing what happens before and after elections — [interposing]

MARK MCCLELLAN: That's right. That's right. All — it's going to be very interesting. Well I'm going to — I'll also want to talk about lessons learned. I'm going to try to take a little bit different tact from Tom. Not that I say that I disagree with what he was saying about some of the likely next steps and certainly some of the issues that'll be on the table in the next year. But I want to talk about sort of the bigger picture on what is our experience with doing large reforms and how could they possibly be sustained going forward.

I think you saw a slide like this from Karen earlier that if you look at the long term revenue or the long term cost projection for the federal government and therefore a big impact on

the deficit, the healthcare entitlements are huge and non-ignorable.

And if you think about strategies for reducing Medicare costs and this is one of two very broad areas. What I think Karen mentioned and what all of us would like to see what is strategies that reduce costs that they drive real healthcare reforms that's – don't impair access and needed treatments but that help us do things right. You know better coordination of care, doing surgery with fewer complications, targeting the right treatments to the right patients and a more personalized healthcare system and so on.

There certainly is plenty of room for improvement and plenty of theory – theoretical evidence and just kind of general descriptive evidence that we can do better in this as well as a lot of specific examples of doing – of actually doing better in specific instances. But actually making this happen on a large scale is really difficult to achieve. And, the CBO and the actuaries have understandably been reluctant about scoring 10 to 20-percent saving or even 2 to 3-percent per year savings which would erase that long-term spending growth.

So instead we end up with a lot of policies that focus more on shifting costs in one way or another. And a lot of times, this falls on the providers through the squeezes in the payment rates. Now you could argue the payment rates are too high but I think there's also some evidence that this does have an impact on what providers can do. It does sometimes lead to some cost shifting

elsewhere. And it does have adverse impacts for getting to that more efficient healthcare system I was talking about a minute ago.

It's also possible to shift costs to beneficiaries. Right now we're in a system where I think according to some recent estimates, a typical beneficiary worked throughout their life and takes Medicare benefits is getting out about three times what they paid in; $300,000 plus verses $100,000 plus. That doesn't seem all that sustainable. And, with given the demographic trends so you know some cost shifting they're certainly on the table.

And probably what we'll see is some of both. I would just like to spend a few minutes trying to talk through some of my experiences suggesting that there are ways to get at steps that can reduce costs and sustain them.

We definitely need to work on this. This is another breakdown of the ACA spending projections from CBO. The stuff above the line is the new spending on subsidies for the Medicaid expansions and the insurance exchange eligibility. Below the line is how that was paid for. And as you all know, there are two main components; the light blue which is new revenues from various tax increases including payroll taxes and on different parts of the healthcare system. And then the lower part which is the squeezes in payment rates and other steps.

If you look at – so you know it's about half and half for those two; more on the latter over time with the market basket minus 1.1 plus other steps forever. But if you look at the total

amount of projected savings, I think you have the close to $500 billion total. I think all but about $13 billion was kind of this traditional way of just squeezing the prices down and hoping that that would lead to something more sustainable.

And I think you also saw — this is from Mike Chernew's work on what's actually happened with Medicare spending growth per capita over time. And the point here is that with what's built in to the current law — to current law which by the way, is not much depending on the IPAB for all the press that it's gotten under the baseline CBO projections. The savings — the projected slow down in spending growth is coming from those [inaudible] price regulations. And if you assume that SGR remains in effect then you're going to get to much lower per capita growth rates out into the future like nothing and actually, you know, some reductions which have never been achieved before.

And Tom talked about all the reasons why that's tough to or experience would suggest that's going to be tough to maintain. The Balanced Budget Act provides some examples of this. It did a couple of different kinds of things to save money. One was these kinds of squeezes on the payment rates. The other was some moves towards more bundled payment systems. Kind of picking up what — on what Tom said and that was difficult to sustain.

So between the SGR and the payment reductions, there's now been a whole series of legislative actions throughout the past decade plus since the BBA was enacted that have offset some of

those squeezes on payments because of the political pressures, the access pressures were getting too big and more coming probably with the SGR in the light.

So what I'd like to do is spend just a few minutes talking about the alternative which is stuff that we've been working on with sort of bipartisan group of people like Joe Antos who's here, David Cutler and others on feasible ways to get away from just squeezing down the prices and shifting the costs to really focusing on getting overall healthcare costs down while improving quality. And that includes the payment reforms like have been or widely piloted in the ACA. I don't think that pilots are sufficient.

It includes giving beneficiaries similar incentives. So when they make choices that reduce costs, they share in the savings just as much as the providers do. And then more efficient ways of choosing among health plans to drive all of those kinds of changes in care delivery. I'm just going to spend a minute talking about my experience with Medicare Part D which as you all know is running now about 45-percent below spending projections. And that seems to be, at least so far, translating into a significantly slower rate of growth than had been projected.

I think there were a number of reasons for this. But a main one was getting back to this core point that I made before about giving people a strong incentive to choose less costly coverage that meets their needs. So Part D had a minimum standard of actuarially equivalence. You couldn't just package all your

benefits up front. You had to focus on high costs and catastrophic protection. But within that, there was a lot of flexibility in how plans could offer benefits.

And sure enough what people chose was not the standard traditional plan defined in the law, the deductible 25-percent co-insurance catastrophic coverage on the back end and the famous doughnut hole in between but whether tiered benefit designs where if you switch from a brand to a generic, you saved a huge amount of money. The generics are basically free. The brand name drugs would be priced close to their actual cost.

Also if you switched from a non-preferred brand to a preferred brand in classes like cholesterol lowering drugs or non-sedating antihistamines where there are a number of similar mechanism of action drugs available, you also get a lot of savings; much more than a traditional insurance design.

And there were a lot of complaints. When this program got off the ground, you all — I see a lot of familiar faces from implementation complaints around confusion, complaints around Medicaid beneficiaries especially not having all their data following them right away in a timely way. But where we were expecting a lot of complaints and didn't get them was around people who had strong incentives to switch from the brand to the generic or from the non-preferred to the preferred. We never got a very high rate of complaints about that.

And a big part of the reason for the cost savings below projections was this change in how people were getting care. So, spending again is prices times quantities. You can regulate the prices a little bit more closely but that doesn't do anything directly about getting the quantities right.

And where a big part of the savings for Part D came from was switching to generics, was switching to preferred brands, was switching to care delivery or treatments that met people's medical needs at a much lower cost. And that was driven on the demand side by consumers. It was not driven by provider payment incentives. Point being is a very important complement to some of the changes in provider payment that have gotten a lot of the attention in the ACA.

There's a couple of cautionary notes here too. When you make a change in policy like this and I'll just use the switch of prospective payments in the BBA which Tom lived through as well. You do get real changes in behaviors. So the prospective payment systems of the BBA adopted like the ones before it shifted the setting of care, led to shorter treatments, led to some bigger cost savings than had been projected. But there were some offsetting effects too to get to this point about capitation that Tom raised as well.

One type of change was that now it pays more to report on diagnosis to get all those right. So you get some reporting changes that may be reflecting real behavior. But that's going to

offset some of the projected savings. And there are these offsetting behavioral impacts. So instead of getting 12 visits after a hospitalization with an episode payment you might get right below the limit and then a whole nether package separately. Or instead of getting a hospital stay in an inpatient setting, you might get in an inpatient setting then a post-acute setting and so on. So the bundles multiple and there are some ways around that through a more comprehensive approach.

It's difficult to score these kinds of system wide savings. They're not incremental. There's typically not as much evidence available on their impact. And scoring typically focuses on federal spending and a big part of what these changes are intended to drive is system wide reforms in how care is delivered that have spillover effects and synergistic effects on Medicare. It's also hard to get more savings I think at this point on provider payment reform. I think CBO has kind of argued that well if there's a provider payment reform out there that Medicare could implement, it's got the authority to do it now. Just pilot it and expand it.

You know one might turn around and ask well if that's true then how come there weren't all these savings on the pilot authority when it was first put into legislation; just that $10 billion. But there it is. And so I think that's a good reason to focus on other reforms as part of this overall effort challenging as it may be to create an environment that makes these current savings projections more secure.

That means steps that may not get scored savings on the provider's side like putting these provider payment reforms together into a more comprehensive strategy to get towards better quality care at a lower overall cost. Something like capitations Tom was mentioning and steps on the insurance choice side in Medicare and the benefit design side in Medicare that reinforce that same goal. Much as we saw happen in Medicare Part D.

So can the future be different? I hope so. This is certainly a first order problem for the United States long-term deficit outcome. But more importantly for the quality of care that Americans are going to receive. And so, as hard as it is and as much as I think, you know, Tom may be right that it's going to be difficult to do any of this in the coming months. If we don't have a focus on improving system wide performance and not just on short-term, you know, incremental Medicare savings, we're not going to get there. We're going to get in a position where we have to take more drastic steps in the future.

And there are ways to do it even in the short-term. There is, I think, bipartisan support for doing something other than just kicking the SGR can down the road a couple more years. There's some ideas along the lines of what I've been talking about here that could be incorporated into the next SGR legislation. There are ways to build on the current authority for payment reforms to have a more systemic impact there, for Medicare to have a more routine way for participating in multi-payer payment reform

efforts, for having standard ways for Medicare to share data to support improvements in healthcare delivery, for having performance measures that aren't just specific to each individual pile that's done but that's represent an overall strategy kind of adding up to the major pieces that Tom was talking about that everybody can see how they fit together.

And then evaluations that don't just focus on each individual payment reform in isolation but recognize that the way we're going to get better care in healthcare in the way that all the private sectors are doing it now is they're adding these together. They're doing medical homes with episode payments with accountable care types of steps and with kind of bringing together the different bundled pieces. They're changing these over time as they learn more but they're keeping a focus on – the focus would be – would stay on better results, lower costs not on isolating each individual particular payment reform in isolation.

And then I think again to be successful, hard as it is to talk about, there are going to have to be steps that go behind provider payment reforms to benefit reforms, to improving the way that the coverage choices are made, all of which will create this kind of synergy or better environment for getting lower costs and better quality. Not easy to get there but some important precedents I've just shown you on both the payment reform side and the benefits side that we can in fact do it. Thanks very much.

ED HOWARD: Great. Great. Thank you very much Mark. And, excuse me; we have time for just a couple of questions. There are some microphones here. You probably don't want to waste your green card, you know in the short-term, better you should spit it out. And, while we wait for you to spit it out, let me just ask Tom a question. Take a – take co-chairs of –

TOM SCULLY: I was going to ask Stuart if he could still do charts for me.

ED HOWARD: Tom, you talked about the give backs in the '90s. And, some people have pointed out that there is a year between when Congress will make a decision on this mechanism whether it's a sequester or the package and when the – at least when the sequester cuts go into effect in January of '13. Do you anticipate that that first session of the next Congress might concentrate not just on dealing with the deficit but maybe giving back some of the stuff that they gave away – took away?

TOM SCULLY: Well at the risk of getting hammered by my friends in the provider world, I think most of the provider folks quietly would tell you that as opposed to somebody – you know the pressure on the Republicans if they – in the super committee is to avoid defense cuts. And so, the likelihood if they do something is probably tougher on a lot of provider groups than a sequester. So I think privately a lot of provider groups are looking and saying professors – a sequester's terrible but if they're going to save

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$1.2 trillion or $1.5 trillion, it's probably a hell of a lot worse if they start getting back in grounding in the provider costs.

So I'm not sure. I personally think there'll be a sequester. And I think it'll last. And I think there'll be – I personally believe a giant budget deal in 2013 that will probably go far beyond that for many years. And I just hope we learn the lessons on the give backs. I mean for those of you who remember as I mentioned home health, home health had an interim payment system for a couple years. It was a disaster until you went to PPS which was much better.

But literally, you know, you could argue the merits. But probably a third of the home health agencies the country disappeared in two years. And no matter what you think of it that's probably too harsh and literally 60-percent of the nursing home systems went bankrupt in two years. So, you know these – there are patients out there that need care. And you know the goal here is of regulators to figure out how to get these people to show up for the marginal next dollar at the lowest margin you can pay and to show up and happily provide the services the next day. And some people may have margins that are too high according to that back there some place else. But you can't provide services to somebody if they're going to go under. And so you get to be careful how you do this.

I mean the fact is any of these people whether they're bond holders or equity holders; they can go invest in a power company or

something else. You got have them show up and provide the services. And you got a lot of seniors out there that need them. So I just think you got to be careful. I think you're going to have a big brutal, massive deficit reduction bill in 2013.

And if we have a Republican President or Republican Congress, which also is possible, it'll be a really big. And history would tell you Republicans will probably way over shoot the mark and may have a really happy two or three years and blow themselves up. If you look what they've [laughter] done in the past.

So, but even if you have a Democratic President, you're probably going to have a pretty Republican Congress. And you're going to have to — those numbers are going to drive everything. And I guess the point of my talk is trying to be is the numbers drive everything. There's only so many places to go. You're going to have a big deficit reduction package. And there ain't enough taxes to increase to get there so they're going have a lot of other things.

ED HOWARD: Okay.

DR. CAROLINE POPLIN: Hi.

ED HOWARD: Yes.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin. I'm a primary care physician. You all have blown past the question of prices to go onto reorganization of the delivery system and reorganization of the payment system. But what did you think of

the article in *Health Affairs* that appeared a couple weeks ago about the enormous differential between primary care and orthopedic surgery? It garnered a lot of attention in the physician world I can tell you.

And MedPAC's suggestion that we reduce what we pay for some specialty care and hold constant what we pay for primary care. I would say a better way to do it would be to maintain steady what we pay for cognitive services and reduce what we pay for procedures. [Interposing]

ED HOWARD: Dr. McClellan. [Interposing]

MARK MCCLELLAN: — the answer to that one. There are a lot of proposals out there to improve the way that physician fee for service payments are set up. For most of them are about ways of dealing with the SGR not about achieving, you know, additional budget savings beyond what's already in current law. And you know there are a lot of tweaks out there that might make some difference. It certainly would make it easier for, you know, primary care doctors to earn more and continue their practice.

I think the specialists on the other side would make the same kind of arguments that you heard Tom just talking about with home health is that, you know, if you go too far, you're going to have a measurable impact on access and potential quality of care. And it's not going to be sustainable. And I think that's why.

I didn't mean to blow past the prices. I'm just saying that look, you look at these numbers. You can tweak the prices a

little bit more. I mean we've tried to – I think we've gone about as far as we can do on that overall in terms of what's in the Affordable Care Act. Because what's built into current law in terms of squeezing down prices for everybody, physicians, hospitals, you name it, is much more than we've ever been able to sustain in the past. So the point is, you know, we got to work on the quantities and the way it carries delivery if we want to get to a more sustainable solution.

TOM SCULLY: Let me just me and my – this debate you could have for hours. I think – I have seven docs in my family. I'm just a rotten lawyer. I'm just fundamentally amazed over the years because I was involved in creating RBRVS in '89. The idea that every doctor, every primary care doc in town, gets paid the same thing. By the way, I think your base RVU is $34. It was $29 in 1989. Think about that concept.

The government fixes prices. You're going to have volume explosions. And the government pays every doctor the same thing. So the 30 year old doc in the med school, orthopedic surgeon, gets paid the same thing as the 58 year old doc who's the best in town. In the history of mankind that's never worked. So my fundamental issue is in Medicare, my fundamental problem with Medicare to begin with is price fixing had never worked. You get an explosion of services and that's fundamentally what we're dealing with.

So, in the long run, this is why I was a big fan of the Part D model. In the long run, I think you're better off having

some third party. I think primary care docs would get paid a lot more by an insurance company trying to [inaudible] better services. The issue is how do you regulate an insurance company to make sure that they have a margin that's sustainable to tax payers. Which I think Part D is a 3-percent profit margin business; it's highly competitive. It's structured in a way that drives prices down.

You can have a debate about MA and other parts of it. But the fundamental issue is as long as the government, as much as I love Arnold's staff in Baltimore, they're wonderful people. They're trying to do the right thing. As long as they're sitting around trying to figure out what do you pay a primary care doc verses an orthopedic surgeon. And by the way, they're doing it through the RUC which is heavily populated and politicized by specialists; you're never going to get a good result.

So you know as far as I'm concerned, we're spitting into the wind. So we can – I happen to be a big fan of paying primary care docs more. But the system is so fundamentally behaviorally broken that you're never going to get it fixed until you get around structural change and the financial incentives.

DR. CAROLINE POPLIN: But it works in Europe.

ED HOWARD: Okay.

MARK MCCLELLAN: Did she say it worked?

DR. CAROLINE POPLIN: It works in – [interposing]

ED HOWARD: I think I would like to let you follow-up but you can do that afterwards if you would. I'd like to try to bring

our second panel up and, let us go forward. If we can hang onto you guys —

MARK MCCLELLAN: Oh.

ED HOWARD: — we want to — we want them to have a second bite of the apple with you, if you have the time.

MARK MCCLELLAN: I thought you said somebody wanted to hang us. [Laughter] [Applause]

ED HOWARD: If that's okay.

MARK MCCLELLAN: Yeah.

ED HOWARD: Yeah.

MARK MCCLELLAN: You got enough chairs there.

ED HOWARD: We're — we are golden space wise. Alright, we have had a sort of high level view of both the problem and some of the solutions that we have — that we have had in the past. And now we're going to come to grips with it in a little more tangible way.

We've got three outstanding analysts who have paid a lot of attention to the Medicare program and the healthcare system generally over the years. And, we're pleased to have Tricia Neuman at the far end of the panel, who's the vice president of the Kaiser Family Foundation and director of its Medicare Policy Project.

Next to me is Marilyn Moon, the vice president and director of the health program at American Institutes for Research and herself a former Medicare trustee. Between them is Joe Antos, the Wilson H. Taylor Scholar in Healthcare and Retirement Policy at the

American Enterprise Institute and formerly a senior official at both CBO and OMB.

Ladies and gentlemen, thank you very much for being with us. And we're going to start with Tricia Neuman.

TRICIA NEUMAN: I'm just waiting for my slides.

MARILYN MOON: Those are a little tiny.

TRICIA NEUMAN: Yeah. Okay. Thank you and hello everybody. So my task is to provide an overview of some of the major Medicare proposals that have been discussed lately in the context of the debt reduction discussions. I'm going to be focusing mainly on those proposals that more directly effect beneficiaries. And many of these proposals are also ones that are more readily scorable which is why they have gotten some attention of late.

I ask that you forgive me if I start to speak quickly because there's a lot to go through and not a lot of time. So if I start to pick up at a very rapid pace, you will at least understand why.

The first proposal I want to talk about is called premium support or defined contribution. In general and these are gross generalizations, the government would establish an amount of money that it would pay per beneficiary. And beneficiaries would use this amount to purchase private insurance. Proposals to transform Medicare into a defined contribution or premium support system differ in many different ways. And these differences are quite

important in terms of what it would mean for beneficiaries and what it would mean in terms of government savings.

They differ, for example, on such basic things as how the government payment would be set, how this government payment would be increased over time, the role, if any, of traditional Medicare, what benefits would be covered, what are the rules for governance of private insurance and other really significant details.

The Administration's Fiscal Commission known as Bowles-Simpson did not endorse this idea but did list it as an option to consider if federal spending exceeded targets. The Domenici-Rivlin Task Force did endorse this idea. And you probably know this idea was endorsed by Congressman Ryan and reflected in the House Budget Resolution.

This approach would be a fundamental change in the Medicare Program. As I said, the savings could be quite significant. And at the same time according to CBO, the increase in costs for beneficiaries could be quite significant.

Moving along, raising the age of Medicare eligibility. Another idea that has gotten some attention, people have talked about it because it would align Medicare more closely with Social Security. And it does reflect the fact that people are actually living longer now than they did in 1965. The Bowles-Simpson Commission included this proposal as an option to consider although it didn't endorse it outright.

Now prior to the enactment of health reform, CBO and others noted that raising the age of Medicare eligibility could achieve significant Medicare savings as you would expect when you move people out of the program. But also could increase the number of uninsured 65 and 66 year olds who would move out of the Medicare program. With health reform, the story changes quite a bit. Sixty-five and 66 year olds would be expected to obtain coverage through another means like the exchange. Medicare would continue to achieve savings but not to the same extend because these savings would be offset by additional federal costs that would occur as the federal government is paying for people who are shifted to the exchange or to — for 65 and 66 years old who are on Medicaid.

Further, costs would be shifted not just to the 65 and 66 year olds but to people on Medicare, to people in the exchange through higher premiums, to employers and others. CBO has projected savings of $125 billion over 10 years for this policy. And they assume a gradual phase in.

The Kaiser Family Foundation release a study earlier this year that looked at this policy. And we assumed full implementation of the health reform law and full implementation of the higher eligibility age in 2014. And this exhibition illustrates two important points. One, even assuming health reform and even assuming coverage opportunities, some people will pay more and some people will pay less in the — in new health insurance arrangements. In fact two thirds of 65 and 66 year olds would be

expected to pay more, one third less. That's on the left side of the — of this exhibit.

On the right side, we illustrated a different point. And that is proposals that achieve Medicare savings have the potential to shift costs onto other payers and actually to increase total healthcare costs just as they are reducing Medicare savings.

A third option — I told you I'm going to go at a clip here — is to restructure Medicare cost sharing requirements. And you probably heard quite a bit about this. Under current law, there's a single deductible for Part A and another one for Part B. There are various co-insurance amounts. And there's no limit on out-of-pocket spending. So people say hey, why not simplify Medicare. We can achieve savings. Make the program easier for consumers. Limit the financial liability for people with a new out-of-pocket cap and mitigate the need for supplemental coverage.

This idea has been proposed by the Domenici-Rivlin Task Force and by the Bowles-Simpson Commission. Some have also suggested using cost sharing to drive people to more value driven services. In general, CBO has looked at this and said this proposal could save about $32 billion over 10 years. But what I — what many people have looked at when they've looked at the effects of such a proposal is, again, there could be winners and losers.

And in general what you would see is a very small share of people on Medicare would be expected to have lower out-of-pocket costs. These are people who are generally pretty sick and use a

lot of services. While the majority of people would be expected to have somewhat higher costs because they would pay a higher combined deductible. And these are the people who don't tend to go to the hospital so they never ever see that Part A deductible which is now over a thousand dollars. That poses a real dilemma for policy makers who are looking at simplify the program but in doing so could create real winners and losers.

Moving onto another policy; Medigap and the idea of prohibiting first dollar coverage. Roughly 9 million people on Medicare today have a Medigap policy. And these policies pay some or all of Medicare's deductibles and co-insurance. When they pay all of Medicare's deductibles or all the co-insurance; that's considered first dollar coverage. And most Medigap beneficiaries today do have first dollar coverage. The Bowles-Simpson proposal would prohibit first dollar coverage. And that's estimated to save $50 billion over 10 years.

I feel like I'm just tossing around these enormous numbers but that's the way that goes. [Laughter] The President's proposal does not impact current beneficiaries but would prohibit future Med – it would impose a surcharge, a Part B premium surcharge, on future enrollees if they purchase a Medigap policy with first dollar coverage. And as you might expect, the savings are less for that proposal – $2.5 billion.

Why does this proposal effecting Medigap achieve Medicare savings? Well according to several studies, beneficiaries with

first dollar Medigap coverage use more services and have higher Medicare spending than others. The flip side of this means of course that if you expose people to higher cost sharing requirements, they will in turn use fewer services. That will lower Medicare spending. But the issue here is will they forego necessary services and if they do, what will be the effect on long-term expenses and of course, on their health?

This map I'm going to just leave you to look at at your leisure but it shows how Medigap reforms will affect people differently in different states. I'm going to go on to talk about premiums briefly because some have suggested increasing premiums paid by Medicare beneficiaries. The Domenici-Rivlin Task Force would increase premiums from 25 to 35-percent of cost. That would save $240 billion over 10 years.

The President takes a different tact. He would address the income related Part B and D premiums essentially freezing the current law thresholds that are now in place. So that over time, a growing share of people on Medicare, 1 in 4 beneficiaries, would be paying these higher income related premiums. In additional, the President's proposal would increase the amount that people pay, if they're paying this higher premium, by 15-percent.

This exhibit illustrates the income distribution of the Medicare population. And I show it to make just a few points. First, there's a relatively small share of the Medicare population with high incomes; 5-percent of incomes over $85,000 which is the

threshold for the higher income related premiums. The other point is that many people on Medicare have incomes that are relatively modest. Half have incomes below $22,000.

So as you're thinking about policies that would increase the so called skin in the game for people on Medicare, it's important to bear in mind that many people have modest incomes and as Karen Davis mentioned earlier, significant skin in the game.

The Independent Payment Advisory Board; it's a whole different kettle of fish in terms of proposals. And I'm actually in the interest of time not going to go through the various proposals that have been put on the table. There are a number but I think as you have heard many of the proposals would actually not achieve significant savings. Even repeal would not – would have a modest budgetary effect with a cost of a little bit more than $2 billion. But many of the deficit reduction and debt reduction task forces would aim to modify the Independent Payment Advisory Board.

There are a host of other proposals on the table; many than we could possibly review today. You may have heard – you have heard about the proposal by the President to extend the Medicaid rebate to Part D plans for low income beneficiaries. That's $135 billion over 10 years. Others have talked about increasing reductions for providers. Some are talking about more skin in the game for beneficiaries, home health co-pays, a higher deductible, increasing cost sharing for skilled nursing facilities.

And others talk about what broader reforms of delivery system reforms integrating care for dual eligibles. I think there are just big questions about what exactly would these reforms do, how would beneficiaries be affected and probably more concretely for this exercise, would CBO score these proposals and what would the savings be.

So in sum, there are no – there's no shortage of Medicare proposals on the table but the search for pain free options we will leave to Marilyn and Joe. [Laughter]

ED HOWARD: Nicely done. [Laughter] By the way, our apologies to Tricia because we had a conference call to discuss this panel and everyone kept saying well you really need to cover that too. Or you really need to do this or distinguish between Bowles-Simpson on this hand and whatever. And I think you did remarkably well. Thank you. Now let's turn for all the answers to Marilyn Moon.

MARILYN MOON: Well, like my fellow panelists, you're not going to hear all the answers. You're going to hear some of the conundrums that are part of talking about what to do about Medicare. And I'm mostly going to talk about beneficiaries but I'm going to pick up on a couple of things that were said earlier as well.

I thought it was interesting that Tom Scully went and made the point that deficits really have driven policy changes in Medicare. And I think that that's correct. That's really what has

happened in many ways. But I think there's a cautionary tale there. One is it gives you some opportunities to do things that might not otherwise happen. And I'm going to talk about one of those in a few minutes.

But it also means that there's an incentive to look for quick changes, big changes and to hope that it's all going to work out well and do it in a rapid fire fashion that does turn out not to be the best policy that needs to be modified later. I'm not sure to say that I feel – take a lot of comfort to say in a couple of years we can fix that in the case of some of the proposals that are out there because a couple of years can cause a lot of pain in some cases.

The other aspect of this is that that means that our focus is on federal payments, what the federal government pays and the assumption being that if we reduce federal costs that we're all better off in some way. And I don't think that that's necessarily the case either particularly when we're talking about things that shift costs off onto beneficiaries.

I think the biggest point that needs to be made in talking about beneficiaries is that these are not frivolous services that we're talking about in the Medicare program. These are issues that are of basic medical care. Medicare is not an overly generous program. It pays only about 70-percent of the costs of the acute care services that it offers. So there's a lot already of skin in the game on the table for a lot of these individuals who are facing

potentially higher costs over time. And that's one thing to keep in mind.

It also means it's hard to talk about them cutting back on those without ending up with a system that is really a poor system because it doesn't cover enough. One of the dilemmas that's currently being discussed about the basic benefit package and healthcare reform and that ones starts out more generous than Medicare for the most part. But we're already talking about cutting Medicare further.

The other thing is that people do then need to get care somewhere. And that means that if it's not going to be paid for by the federal government, it's going to be paid by individuals' families, former employers and in some cases, providers of care if individuals can't pay. The costs don't necessarily just go away because we reduce federal spending if this is necessary and needed care. And that's a difficult thing to deal with and to understand when we're talking about whether or not we're better off as federal costs go down and if that's the calculus that gets used.

So I've already mentioned then that the costs are high for individuals and the benefits low. So I'm always very skeptical when people talk about putting more skin in the game. That said however, I think there is one opportunity of a deficit reduction strategy that we should keep in mind. And that is that the answer is out there for anybody who's going to squawk that's already kind of on the table and that is everybody's going to have to give

something up. There's going to have to be shared pain. And that may allow us the opportunity to make some changes that actually move in the right direction that a lot of analysts for a long time have thought would be an improvement but because there are more losers than winners, for example as Tricia already mentioned, it gets off the table and doesn't get discussed.

So I think for example, restructuring the benefit package where you talk about adding an upper bound, an upper limit on what individuals will have to pay is a very good idea even if you have to pay for it by high — raising the deductible, for example, on Part B or providing a combined A and B deductible. And you may even squeeze a little bit of sayings out of it although I'd be very careful there as I mentioned before because we don't want to see the coverage that's offered under Medicare go down too low. But it is a way of making this insurance package that Medicare offers more rational than it has been in the past and much more like insurance that other people have.

That also may make it less likely that people find it necessary to have supplemental coverage over time something that's also been a legitimate concern of individuals. If your insurance package under Medicare looks a lot like what you had when you were under 65, you may not see the need for first dollar coverage under Medigap whether or not you do something about the Medigap issue. So from that standpoint, there is a case where I think you could

add a little pain. You could make the system work better but you need to do it very carefully.

I'd also look very carefully if I were going to do that not at just blanket across the board increases in cost sharing but think very carefully about where you want to change behavior. One of the things that people will tell you is that when you put more skin in the game, you get people to use fewer services. That's absolutely right. That comes from the RAND study many years ago that is the gold standard that everybody using. But they often forget to tell you two things about that study.

The first thing that they forget to tell you is that study found that the income effect was much stronger than the price effect. Now what do I mean by that? I want to use my economics jargon here. That means that what you get is a much bigger response from low income individuals who simply can not afford the care than an across the board adjustment when people see they have to pay a little more for the care they receive.

Frankly, I'm at an income category where if you raise my cost sharing, it's not going to change my behavior very much at all. If you took at one of those people that are under $21,000 of income as Tricia was talking about, it will have a big impact on their behavior. So that's something very important to keep in mind.

The second aspect of that to keep in mind about this is that we also know when people cut back, they do so indiscriminately

because many of us don't know and can't distinguish between necessary and unnecessary care. And the RAND study also found that people when they cut back cut back necessary care and unnecessary care in about equal proportions. Again not necessarily driving us where we want to go.

So if we're going to change cost sharing, let's do it in a smart way. Let's look for those things that we want to see people use less of and increase cost sharing there. Let's not just do an across the board increase. That may mean, for example, lowering cost sharing on primary care visits, raising them in other cases, raising them on the basis of evidence, doing other kinds of things of that sort. An income related upper limit cap may also be helpful for example. So there are a lot of things to look at there that I think are important to take into account.

In the short time I have left, let me just mention a couple of other things that I think were raised. I'd be a little careful before I was too optimistic that Part D was the answer to all our prayers in terms of showing how competition works. Part D did do some good things and I'm the first to admit that pushing people into generics was a great idea. That's one of those again where you're actually pushing people to do things that are good for them and it's a win win proposition.

But Part D also costs less than people thought it would because more employers stayed in the game than anybody predicted in the beginning. And that may sound great and maybe that's fine but

it has nothing to do with competition in the private sector. It's also the case that there are other things that were happening in the market that were driving these changes anyway. Part D has some real advantages and some disadvantages. And let's just not go too overboard.

The other thing is when people say think how many people will come if you offer private insurance and Part D was wonderful. Never forget that the federal government picks up most of the risk by having catastrophic coverage at the top end. And most insurers who are told, here you go, you get a pretty limited set of liabilities in a very narrow range. Are you willing to play? It turns out they were. That's a good lesson but it says you got to be very careful about what it's telling you.

And lastly, I would caution we should not look for quick savings. Many of the things that are most promising that I was glad to see talked about by Tom and Mark are things that are going to take a longer time to achieve savings and need to go across the board and affect everyone. Those are the kinds of things we need to concentrate on but they won't give you $100 billion next year. And in fact, if anyone promises it, run in the other direction. Because you need to invest in some of these things to make them work well or else they'll turn into the kind of slash and burn changes that then get reversed two years later because people are running away from them even when parts of them might have been very good ideas.

So I would caution against looking for quick savings and say that but that's the area where we really should focus. And I commend Mark and Tom for talking about that because I think those are promising areas and where we should pay a lot of attention.

ED HOWARD: Terrific. Turn now to Joe Antos.

JOE ANTOS: Okay. Well let's not forget that there is this Joint Select Committee on Deficit Reduction. And so their focus is in fact on quick savings. [Laughter] Alright? Alright, so that's the first point. The second point is if you don't want any losers then you don't want to make any changes. Somebody's going to lose. I mean the whole point of reducing Medicare spending is so that somebody doesn't get some money. I know it's shocking but it's true. [Laughter]

So that being the case, let's be adult about it and recognize that Medicare is not a sacrosanct island unto itself. It's part of our overall policy priorities that the federal government is attempting to carry out. So we want to be careful about this and try to remember that there is a broader context.

Now, nobody mentioned this but Tom did mention that the sequester. The sequester's a great deal for Medicare because it would only be a 2-percent cut. And by the way, now the word cut, you know that's just a relative to the baseline. Is it really a cut? No. It's a reduction in the rate of growth. And a 2-percent cut for Medicare under the sequester would be $123 billion through 2022. And since it would be roughly divided out evenly in 2013,

it's not an enormous amount of money. It's you could — Medicare could handle it. And there is some pretty easy conceptionally politically difficult policies that you could follow.

Now, you know if the Joint Select Committee does its job; it's going to come up with a lot more than 2-percent Medicare cuts. Because, one of the imperatives that they're facing is that failure to do that means defense cuts of about — let's say, what's the total?

MALE SPEAKER: Nine percent maybe. $450,000.

JOE ANTOS: Yeah. Yeah. About five — well it's about five — say about $500 billion — something like that. And, there are members of the committee who even — they may be Democrats but they have major defense contractors in their districts. So, that's a real issue. So on balance I think we're going to see a lot more than this 2-percent cut for Medicare come out of the committee. Whether that means it gets passed this year or not, I think is a real question.

Now CBO; if CBO doesn't score it, it isn't deficit reduction. That if CBO does score it, it doesn't mean you're going to get the reduction. [Laughter] So you know heads I win, tails you lose. [Laughter] The — and furthermore, if you have — if CBO scores a reduction, it scores it over 10 years, right? So, if you take again a conceptionally easy hit, you know a provider reduction or something like that, they'll score it for 10 years. And even if it's a highly reliable one like reducing payment updates for

hospitals, something like that, highly reliable there's very little doubt about what the budget savings would be.

What about year 11? And actually for that matter, what about year two because the current Congress can not bind the actions of future Congresses. So it's we have real problems here. What you — what we need is a mix of near term and long-term reforms. I think it's unavoidable. Certainly the Joint Select Committee needs to have some mixed there. We need to adopt provisions that aren't just going to produce CBO scores. We need to have forward looking provisions.

We need political risks here. If there was ever an opportunity for Congress to take a risk and then shake it off by Christmas — that's possible — this is it. This is a great time for somebody to say well why don't we try something that's a little bolder. Business as usual with a few tweaks isn't going to be enough. Remember the perspective shouldn’t be the next couple years, the next 10 years; it should be looking over the longer term.

And then also we need to be honest about our budgeting. The sustainable growth rate problem needs to be part of this. We go through an annual charade. Just because we up the payment rates one year at a time doesn't mean that we spend any less money at the end of 10 years. So we need to deal with this honestly. That's a $300 billion hit. And so, well good luck to the Committee.

So what should we do? Short-term near term policies, I agree with Marilyn and with most people, we need to rationalize the cost sharing. Part of this — and deal with the Medigap issues — part of this has to do with; I think Marilyn used the expression shared sacrifice. I think that's a really important consideration. The Medicare Payment Advisory Commission made some recommendations last week, was it, to "pay for getting rid of the sustainable growth rate".

And so what were the recommendations? Well they said well let's have a general freeze on physician payment. Let's take a cut off of specialty services and do a freeze there. For primary care, let's just have a freeze. In other words, relatively speaking, primary care moves up a little bit. They also had some recommendations about cutting into other providers and some — I can't remember exactly what it is but something having to do — that would affect beneficiaries directly as well.

So what did we get? We got a hail of complaints. No, don't touch my money because I produce very important services. Well everybody does. Again, the question is; are we going to deal this — with this problem in an adult manner or not? And that applies to beneficiaries and to Medigap insurers and to private employers just as much as it does to providers.

I think easing up — easing the eligibility age up slowly makes a lot of sense. It makes a lot of sense because when you think about how we pay for anything in federal government, the

answer is that wage earners cover the bill. Once you've quit working then you are a beneficiary. You may not be a beneficiary of Medicare but you're a beneficiary of something. And by and large when you've left the work force, you're receiving. You're not contributing on balance to the — again the social priorities the federal government is attempting to finance. So that makes a great deal of sense to me.

Of course we're going to see probably as Tom predicts massive recommendations for massive cuts in payment rates to providers. They don't have to be massive but payment rates are going to be cut. They're going to be cut whether the Joint Select Committee makes major recommendations in that area or not. That's just the way Medicare operates. As Tom said, everything runs on the basis of the budget. But, you know let's be realistic about it. Let's be sure that we realize that future Congresses are likely to smooth some of those sharp edges off maybe fairly abruptly.

The other thing that I think is very important is that when the Joint Select Committee or Congress thinks about what provider cuts to take, they really ought to think about what the impact is not just the impact on the federal budget, not just the impact on — the potential impact on provider — I mean beneficiaries but also the impact on access to care and innovation. There's some hits that are safer to take than others. And, we need to try to identify those and take those.

And then, finally, you could increase premiums. We're doing it now. But in the end, revenue is not going to solve the cost problem. It's the cost problem that needs to be solved. Okay. So over the long-term what should we do? We need to change financial incentives in the system. The current method doesn't work because we're fighting against ourselves. We've got traditional fee for service Medicare. If you do a service, you get paid. If you don't, you don't. You have the promise that is a little – not quite as strong as it used to be but it's still there that the entitlement is essentially unlimited. So we're fighting against ourselves.

The financial incentives promote the use of services. You know I don't think anybody can argue that the fifth MRI for some condition that you have is likely to be that useful to you. It's just not at all clear that we're going to be able to use top down controls to limit unnecessary use of services. Again MedPAC has a proposal to look at radiologists who are high utilizers. Well that's a great idea. How many services could there be high utilization where you'd want to do that? All of them potentially; so you can't – that doesn't work.

And then the other side of that is that we're fighting the battle with one hand tied behind our back where we tend to focus only on the supplier's side of the market. We don't look at the consumer's side. So if we could get both sides aiming at the same thing we may get some results.

One last thing about the concept, not necessarily the specific proposals, the concept of premium support; the concept of premium support is not fundamentally to shift costs to beneficiaries. It's to put Medicare in a budget. It's to give the health sector the message that the gravy train is going to stop at the station. It's not going to continue on. But if you want to be more profitable, you have to find ways to become more efficient. That's at least the goal of it. It's not really to say to my mother okay; well you're going to pay a lot more. The reality is my mother isn't going to pay a lot more. And most mothers aren't either because they don't have the money. So clearly, that's a way to put a budget limit that would be a very clear message to providers and health plans. I think it's a very important message.

ED HOWARD: Alright, thank you Joe. And we now have a chance for you to join into the dialogue. There are questions. There are question cards. And let's start off with a question from Karen Davis.

KAREN DAVIS: Well I thought I'd grab the microphone. Trish was rushing over her last slide but she mentioned dual eligibles. And I was curious from you or Marilyn what the potential is for savings and better care for beneficiaries who are covered by both programs.

TRICIA NEUMAN: Well you know, I think people are well aware and concerned that dual eligibles are among the oldest, sickest, frailest, highest users and they account for a large share

of spending under both Medicare and Medicaid. There is a lot of hope that programs can be developed to impose targeted interventions that would, for example, reduce hospitalizations, emergency room visits. People talk about capitation as a strategy either Medicaid plans or Medicare plans. People talk about bundling.

But I – you know I think we're at a point where there's more hope than evidence. And while there is great promise maybe in doing a better job in delivery care for these most at risk beneficiaries, some of the proposals that are out there suggest, you know, $150 - $200 billion by sweeping Medicare – the lowest income Medicare beneficiaries and putting them into plans having Medicare dollars flow to the states to manage the care. And I think we're early on in the evidence to see how that will all play out.

CMS is – does – is working with states to develop some planning programs around this idea. And I think we'll have to see what the states can do.

MARILYN MOON: Let me just add that I think it's important that there are at least three groups of dual eligibles and there may be more. One is a group of people that are dual eligibles simply because they always have had low income and they are just sort of generically unable to be – to pay for care whether it's a little or a lot. Then there are the folks who are in the long-term care system and they end up on Medicaid in part because they've

spent down and because long-term care is phenomenally expensive. And then the third group are people that have very high expenditures but they're acute care driven expenditures that cause them to be low income.

And when people talk about dual eligibles, they often talk about while we can just have this one program and enroll everybody in together. This is an area where it needs to be done very intelligently and in terms of recognizing that there are different kinds of needs out there. And there are different kinds of ways in which you want to try to work on this. This is where the big costs are but this is also where people are extremely vulnerable. And we need to be very careful about that.

JOE ANTOS: Let me add a quick thought. The — it's not just dual eligibles who can be expensive patients. There are complex patients in Medicare who haven't quite made it to Medicaid yet. And so, I think a reasonable strategy is to look again at chronic care management programs. There's some hope that these kinds of programs have figured out how to do it. If you focus the management, the coordinated care on people who are really the expensive people rather than on everybody, you — it's likely to be more cost effective.

ED HOWARD: Yes, I think we're ready. I don't know who is first but go ahead. Mike, you want to identify yourself.

MIKE MILLER: Thanks. Thanks Ed. Mike Miller. I just wanted to follow-up on some of the Part D discussion that Tom

started and other people followed up on. You know historically it was the idea for the drug benefit came from, I think it was the '97 bipartisan commission looking how to reform Medicare to save money.

But then when you guys were in CMS, it was how do we spend the money because we have the surplus. So originally it was it came out of a discussion about saving money and they decided putting the drug benefit was a good way to improve the program. And you know I think Tom or Marilyn said success was, you know, switching to generics. That held the cost down but also the success of the program was so many more people in Medicare now are getting the drugs that their physician said they should. So I think that's the big success.

But, and what Marilyn said about changing people's behaviors and changing benefit structures. One of the challenges that Part D has, I think 10-percent of seniors still are not getting prescription drug benefit. I mean if that was Part B and 10-percent of the seniors weren't signing for Part B that would not be seen as a great success.

So I guess the question I have here and I am getting to one is that – and people are talking about innovations and how restructuring payments under Medicare, it seems to be a lot of A and B, A and B. Is – how do we get to a discussion maybe where it's A, B and D to bring all of the services together and transform incentives and behaviors around all the services? Because a lot of

the innovations I see out of CMMI and other places are talking about just combining or doing things in tandem with A and B.

TOM SCULLY: Let me — let me —

MARILYN MOON: I think that's a really good point because the — one of the real problems of having D be so separate from the rest of the program is that savings that can be achieved from really good medication controls and oversight aren't going to be — there's no incentive to do that if it's going to reduce hospitalization. And the drug plan has no incentive to do that for example. So I think there needs to be a lot better integration. I think that's a good point.

TOM SCULLY: Well let me — let me —

ED HOWARD: Tom.

TOM SCULLY: — just be clear. I think that you should all sprinkle Part D on your Wheaties in the morning. [Laughter] So look, Part D's worth — part of the problem I think we have here is the rhetoric of old programs. So, and we can get on the between Medicare and Medicaid. Part D is premium support. So we didn't have the option; Medicare Advantage was there. I think Medicare Advantage is somewhat of this flawed program.

You know the original goal in this was the fellow employee health benefits plan which is in fact looks somewhat like Part D and is a better model than Medicare Advantage is. And if you're trying to get over [inaudible] Part A and Part B and Part D, you want to do it in a private insurance model that works a little

better than probably Medicare Advantage does. And I think that model which I advocated for years is more like the Federal Employees [Health] Benefits Plan.

What does that do? And I think it's not a flaw. I think it's a strength. We realize if you're trying to get insurers to show up for Part D, you have to give them some catastrophic stop loss and you have to give them risk quarters because it's a risk they're not familiar with. So they did show up in big numbers. But the benefit of it is; it's a low margin, fairly low risk business with private decision makers deciding what you're paying for the generics and what you're paying a doctor and what you're paying a hospital. And it drives much better behavior. And it also drives because you're not paying them to take all the risks much lower margins. And you get services at a lower cost.

So, I for one am a big — and I think we get beyond this because premium support is not a dangerous thing. Part D is premium support. The Federal Employees Health Benefits Plan is premium support. But because of the politics, they'll say oh my God vouchers. Vouchers are terrible. You get the same thing in Medicaid. People say block grants. Twenty-five states have per capita allocations under waivers that effectively get a per capita amount.

Now is that a block grant? I'm not a fan of block grants because the minute somebody mentions block grants the Medicaid people run the other way. Twenty-five — at least 25 states — when

I was there, it was 25 states — have a Tennessee, Missouri type situation where the governors come in. The Democrats and Republicans said give me X number of dollars per person adjusted for inflation, population growth and other things and let me run the program myself.

Is that a block grant or is that a much more flexible rational way to run a railroad? But we get so caught up in the rhetoric of block grants and vouchers verses premium support and flexible state benefits programs. And that's half the problem you got in solving the healthcare problem. I — you know I'm — helped, you know, I did — the best we could to make Medicare Advantage work better. It's got some payment flaws in it. Part D is a much better, much more competitive, much better structured program. We didn't get to start from scratch with MA. We did with Part D and it works a hell of a lot better. So put it on your Wheaties, it's great stuff.

ED HOWARD: Mark.

MARK MCCLELLAN: I don't know about the Wheaties but it's — just make another set of points related to the care coordination issue that Mike brought up earlier. I think there — that there is a good deal of evidence now that Part D is saving money elsewhere. There were some papers done recently. They draw on American Medical Association for example that estimated cost savings through reduced hospitalizations and other complications may be getting to sort of one fourth of the overall cost of the program.

Another indicator of this, if you look at the premiums for Part D in Medicare Advantage where the plans actually do see the kind of the overall savings impact, they're running about 10-percent or more lower than in the fee for service Part D stand alone benefit. I think that's a reflection of, you know, both better coordination overall and these kinds of offsetting savings.

I think the question is if that's a — you know if you want to promote more coordination like that, how do you make Part D less of a stand alone model for fee for service. Joe had some suggestions earlier about maybe encouraging programs that deal with high risk patients. That certainly are a lot of payment reforms being piloted now that could be better integrated with the use of drugs to manage risks. But, if you really want to get to the kind of goals of better coordinated care, you got to move out of the silos. And I think that's a good reason to take steps like that with the Super Committee's work now.

ED HOWARD: Mark, let me just ask you and Tom. How do you get CBO to score those kinds of savings so that the Super Committee will at least be willing to take those kinds of actions to get to their goal?

TOM SCULLY: Well —

ED HOWARD: After all, we have a [interposing] former OMB guy and a former counsel [interposing] of economic advisors guy.

TOM SCULLY: Premium support by definition saves money. I understand it's scary. And there's a debate because when we talked

about the premium support for what's now called MA in 2003, people went nuts because seniors – because you know seniors' premiums could go up and their costs could go up. All of which is true but you can put in caps and limits on how much that can change.

So you can – you could drive to a more competitive system and get more people into a totally capitated system. You also don't have to have the plans take full risk. I mean if you look at old programs that have now evaporated like Medicare Select, very flawed Medicare cost program, where you essentially have capitated Part B which you talk about an ACO. I mean those were two programs that totally capitated Part B payments to physicians and outpatient services. So you don't have to capitate the whole program, you can capitate pieces of it.

You know I admire everything Don's doing with ACOs and what you've been with ACOs. But it really is capitation light, light, light. And if you – you know there are other way – models to do that. So, there are a lot of different ways you can do it. You know the Federal Employee Health Benefits Plan, for example, does not – the insurers don't take risks. It's basically an ERISA, the federal government acts almost like an ERISA player. So, and it's – as a result, that's a much different structure. It's a totally different structure than MA.

So, you can come up with more capitated private payer models with the trust funds, for better or worse, are still kind of at risk. And as a result of that, you have lower margins, lower

profit margins and arguably lower costs to the government if you want to do – that's roughly what – if you look at what we did with the risk quarters which we made up one day in Part D; it was very – you know Stuart was around. He remembers it. You know that was basically kind of made up lim – you know there's a way to limit the potential loss of the insurers coming in. And it was almost a quasi, you know, self funding ERISA model for the federal government to take risk for plans. There's nothing wrong with that. I think that's an advantage we did that.

MARILYN MOON: I think the issue is whether people like Mark McClellan or Tom Scully will be in charge or whether there will be somebody who says great, now we just get the federal government out of worrying about this. And we just give payment amounts out. And I think that that's the real challenge and what the fear of a lot of people that this is an area where you really need lots of players in the game to try to figure this out because it's complicated stuff. And there are lots of incentives and unintended consequences.

And if you had all the right protections, a lot of people who've been critics of premium support like I often have been would have a lot fewer criticisms. But, the concern is that a lot of support for premium support is driven by people who want to see government just get out of game.

MARK MCCLELLAN: You know there's a difficulty in it. I don't know if CBO's ever scored a Scully effect. I would be

interested in seeing how that estimate [laughter] some comments on it myself. But, there's a challenge for CBO in evaluating these kind of broader reforms to do more than just tweak a payment system in a way that has a fairly predictable impact at least in the short-term because there are going to be behavioral responses.

I mean that's the main place where the longer term savings, as we've been talking about here today, come from. It's not from, you know, generic drugs being priced a few dollars less. It comes from big changes in behavior because of a new system. It's not from, you know, moving to a little bit more bundled payment per say. It's from the changes in the way that providers put together services and in response to that.

And, I don't know that you're going to get very big scored savings in the short-term for that reason. I think on the provider payment side, CBO really does feel like there's a lot of authority out there that's not yet being used. And therefore, maybe additional legislation wouldn't make much of a difference.

But you saw from Tricia's presentation that, you know, in terms of how people choose health plans under some version of premium support which could be done as Tom emphasized in a way that and Marilyn said in a way that doesn't shift a lot of cost. It really does provide stronger incentives for beneficiaries that choose more efficient plans, other ways to promote more efficient benefits that would encourage coordination that would let beneficiaries save more. Just like they do in Part D when they, you

know, get their overall. They do a better job with their overall care in terms of choosing providers and using treatments and so forth.

And I think there are a good amount of scorable savings that could be put together from those pieces. What you may not get is the, you know the — I think Joe was alluding to the — you know sort of the synergistic effects of changing the whole system so that all of these — you know all of these policies are rolling in the same direction. That's hard to score. But I think combining that with some scorable savings makes for a pretty powerful approach to driving reform in the right direction.

ED HOWARD: Okay. I actually think we're going to have time for the folks who are at the microphone now. So go ahead, Gary.

GARY CHRISTOPHERSON: Gary Christopherson, former lots of federal things. The good discussion but folks that have essentially been on the federal government Medicare or Medicaid, essentially it's been about moving dollars around from one place to another. The question is in that effect. What I would like to go back, two points, kind of pick up on Karen and the group that have been dealing with the high performance health system. And on two points which makes healthcare very different than much of the rest of the world.

One is we're probably the only world where the idea that we actually pay lower price for better outcomes doesn't happen.

Anything that new happens in health innovation tends to cost more than the previous thing and more and more. So we don't get any savings out of things you get in other worlds.

The second part which was touched on very briefly was the issue of we pay for a lot of care that reproduces very little benefit. So the question if you're really trying to look at more than just Medicare or Medicaid but look at the whole payers as one big community, the question what we do about one getting a better price off of innovation than we have currently done for better outcomes. And the second part, paying for the right things, which was alluded to briefly, as opposed to paying for a lot of things that just don't produce a lot of benefit.

ED HOWARD: Tricia.

TRICIA NEUMAN: You know one thought is to have – it – the health reform law created the IPAB. And the IPAB was very focused on Medicare. And it was focused – it is, I shouldn't say was. It is focused on Medicare. It is focused on savings.

One could envision a separate entity that's thinking much more broadly about the healthcare system and thinking about changes that could affect all payers, moving people to services that have higher value, moving people to services that have better outcomes. It seems that that might be an approach that kind of recognizes that we're all talking – we're – we recognize we're all kind of in it together. And there is a lot of shifting.

And really what we're trying to do is figure out how to get all of us better healthcare and not to have too much utilization, to have better incentives for providers and for beneficiaries. And it seems like a – you know a separate entity to be thinking about that but not just related to Medicare or as we have now in CMS, the Center for Medicare and Medicaid innovations. Just thinking about those two programs, broadening that out I think would be a great idea.

ED HOWARD: Marilyn.

MARILYN MOON: I also think that one of the things we have to be very realistic about is that I agree with Joe that you're not going to be able to do top down controls and expect to change the system. And one of the key pieces that people – we haven't talked about today that I think is really important is that is helping consumers understand more about healthcare and developing a more informed consumer population.

Just think of the coverage that's just come out over the Preventive Services Task Force talking about prostate cancer screening and the reaction of people who instantly say well I had it and it helped me. And therefore, it has to be valuable. We don't have a very informed population. We have a population that has been told over and over and over again that more is better. And as much as you can possibly get is the best. And as a consequence, ask for everything.

So I think we're going to have to bring consumers along in this debate and discussion. And if we're going to hold them accountable as I suspect we are more and more, we also have to give them some tools to make some of these decisions well.

TOM SCULLY: Ed, can I —?

ED HOWARD: Okay.

TOM SCULLY: Yeah, I just —

ED HOWARD: Go ahead Tom.

TOM SCULLY: I'm an unabashed fan. This thing could happen in my lifetime but there are some people that are a lot younger than I am. So maybe, you know we have three totally nonfunctional payment systems. All of which are well intentioned Medicare single payer. Medicaid has its own set of disasters. And the commercial sector, even if you assume President Obama's exchanges come into place, will be better structured. But it's still you got three different competing sets of incentives.

So I've long been a fan of the Ron Wyden approach. I mean the right thing to do is to come up with one set of well structured and they probably look a lot like President Obama's exchanges. One set of plans in every area that's well regulated where somebody buys a health plan and then they're subsidized based on their income whether they're poor or their age and their status in life.

You don't have three or four different competing sets. All the incentives are out of whack. And even though I think people in healthcare are the most honorable people in the United States, they

still follow the money. And the system follows the money. And the incentives from the three different payment systems, Medicare, Medicaid and the commercial sector are completely different. And it all happened by accident largely after World War II. It's nobody's fault. It just is what it is.

And so I know Senator Bennett, a good Republican, bit the dust for being for the Ron Wyden plan. And I know Ron Wyden is not your conservative Republican. But if you look at what's the right thing to do in the long run, if you're 30 years down the road and you're a health policy analyst. Until you get to the system where you have one set of incentives with the subsidies based on income and age, not based on where you happen to fall from a system that was accidentally made up, not much is going to change. And I — so I'm a fan of Ron Wyden's plan. I may be the only one left. [Laughter]

ED HOWARD: Yes, go ahead.

SUZANNE MINTZ: Suzanne Mintz, National Family Caregivers Association. But I do not have a caregiver question. I've heard a big insurer recently and a provider group all talking about how much money we could save if we really went after fraud and abuse. And that hasn't been discussed here at all. And, what do you think of that as an idea for bringing costs down?

ED HOWARD: I think the panel's unanimously against fraud and abuse.

FEMALE SPEAKER: Absolutely. [Laughter]

SUZANNE MINTZ: But that's a pretty good bet.

ED HOWARD: Okay. Now, does somebody want to respond to the actual question?

JOE ANTOS: Well you could eliminate all of the fraud and abuse but it wouldn't change fundamentally the cost arc. So we have to really deal with the legitimate delivery of healthcare. That's — I'm not going to say that's where the problem is but that's certainly where the spending is.

The other negative side of anti-fraud and abuse things is there's going to be an awful lot of people, youngish people with big muscles in Florida who are going to be old looking for another job. [Laughter]

TOM SCULLY: Well if you could just get rid of Dade County and give it to another country, you'd probably be [inaudible]. [Laughter]

ED HOWARD: Well how about that? [Laughter] We're going to — by the way, we're — I'd like as we go through the last part of the program to encourage you to pull out your evaluation form, the blue form, and fill it out so that we can improve these programs.

And now, we've asked Karen Davis to step out of her role as co-moderator and to kind of synthesize and point out the major topics that we have covered. And if you've seen Poppy Montgomery in *Unforgettable* in the new season, you know that she has no rival other than Karen Davis who not only summarizes with perfect memory

but has the ability to draw conclusions that are useful for the discussion. Karen.

KAREN DAVIS: Well with that set up [laughter] I think what we heard is that the Congressional Budget Office is the score keeper and will shape largely how all of this rolls out. And it's easier for them to estimate the effects of the tried and the true than the unknown and, the bold new territories. So, more weight will be given to provider price changes, benefit changes, premium changes which are pretty straight forward in terms of estimating them.

I thought we had a lot of pithy political advice. So I like that, having Tom kick off, I thought his point that budget savings always drive Medicare policy is interesting. It's true. We don't do these difficult things unless we have to. I read what was being said is that a sequester is likely. We'll all watch with bated breath and see if we're wrong about that. But that the election will matter and that the big changes will come in 2013 regardless of whether there are small changes in 2012.

The difficulty is that it's hard to bridge the political divide. On the other hand, what's feasible depends on the circumstances. I always think it depends on the Chinese bumping the dollar. So maybe the – that in the future world, economics will drive Medicare policy changes too.

We also heard from Tom in some of the tough choices he had to make that what rose to the top was the least bad idea. And we

heard from Marilyn Moon that we're going to have to have shared pain. So again, that may be in our future. But I also think we – we looked at that gap between tax revenues being at 15-percent of GDP and spending being at 25-percent of GDP. We're not going to fill – close that gap with also – without also dealing on the revenue side. And in fact, dealing on the revenue side will help us make some changes that really aren't so severe that then they get turned over and to – oh, over time but in fact lead to realistic policy solutions that can stick.

In terms of the policy solutions, I heard those that are likely in the short-term, those that are doable in the long-term that we should all be working toward and those that will not appear in my lifetime. [Laughter] So, turning to the short-term, I thought there was a fair amount of discussion about fine tuning the cost sharing that's in Medicare. It hasn't been fundamentally changed since 1965 and that there are arguments from moving toward a more modern structure including combing the A-B deductible with a limit on total out-of-pocket spending but maybe conditioning that out-of-pocket limit on income.

A fair amount of discussion about raising the age of eligibility at least to 67 as we are with Social Security. And how that's much more feasible with the Accountable Care Act that will prevent people falling through the cracks and becoming uninsured by giving them another option for coverage but which will also offset some of the savings of increasing the age of eligibility of

Medicare. And I think there was a fair amount of recognition that we're probably going to keep moving down the income related premium path with more revenues coming from that.

Also in the short-term addressing the sustainable growth rate, it's – it has to be. So whether it just gets kicked further down the road or some changes along the lines of what MedPAC has recommended with freezing primary care and permitting some cuts to go on forward on specialty care or things like radiology. It seemed to be likely. So those were kind of some of the ideas that seemed high on the priority list for short-term.

On the longer term, I think there was some interest in the dual eligibles. But the caution that they're very different populations covered by both Medicare and Medicaid. And they required different solutions. For those who are really high cost acute care utilizers, it may be that the chronic care management care coordination, high cost case management, medical home, whatever the strategies are may be effective. For those who are long-term care patients in nursing homes or served by the home health system, avoiding the bouncing back and forth between hospital and nursing home, achieving savings and then a different view toward those that are simply low income without being quite so severely impaired having different solutions for that.

Over the longer term, trying to have more sophisticated win, win, win solutions. Joe Antos said there's always a loser. I'm just one of these Pollyanna's that always thinks there's a way

to do it all. Better access, improved quality, greater efficiency; there are those solutions but they take time to test. We have the Center on Medicare and Medicaid innovation now charged with testing those kinds of ideas.

Mark McClellan said we need to use that existing authority particularly moving toward multi-payer initiatives that have Medicare joining with Medicaid and commercial payers, giving fast data feedback on what's working and trying many things at once. Not having that little medical home initiative or pilot over here and accountable care organization over there, a beacon community and an IT initiative over here but really trying multiple things at once and, but particularly learning quickly from that. And then using the authority in — of the Independent Payment Advisory Board for the Secretary to spread what is found to lower costs or improve quality more rapidly across the Medicare program as a whole.

But also some discussion that really says IPAB, if it comes into existence as planned, will also need some restructuring. Probably needs, as some suggested, to look beyond Medicare to all payers. It now can make voluntary recommendations with regard to private payers. But really look at the health system as a whole, have a longer time window for recommendations, get into some of these thorny issues like applying comparative effectiveness to insurance design, make recommendations as the President has put on the table with regard to moving Medicare toward a value based insurance design program.

There was a question about whether there will be big changes in provider behavior in response to a whole new set of incentives, a bundled payment. But we had interesting examples; the DRG experience in the 1980s where you changed the way hospitals were paid from cost based reimbursement to a single bundled price for an admission. All of a sudden, the lengths of stay came way down. Tom talked about what happened when we knew – moved to perspective payment of home health. All of a sudden there was a better way of providing that service more economically. So new – moving away from fee for service toward bundled payment total global payments for total care of patients may well have great potential for the long-term.

What was it about not in my lifetime? I personally put premium support in that category. It's interesting. It wasn't in the President's proposal. And I think what we heard from Marilyn Moon is it depends on how it's indexed. The original proposal put on the table was to index it at the CPI eroding the value of that support over time and not dealing with the underlying cost problems. So, the ability of even private insurers to respond when costs particularly to private insurers from prices charged by providers are going up it seemed difficult to imagine even in the long-term.

Shifting major cost burdens to Medicare beneficiaries also not feasible even in the long-term given the demographics of poor and sicker beneficiaries. And probably I would put in not in my

lifetime accrued across the board slash and burn price changes that are unlikely then to really hold. So, that was my take on the session and [interposing] turn it back to Ed.

ED HOWARD: That's – that is terrific. And, Joe, you had a 30 second comment?

JOE ANTOS: Yeah. Yeah.

ED HOWARD: Did I understand?

JOE ANTOS: Or less. That was a great summary, Karen. Just an explanation, is Karen really more optimistic than I am? I don't think so. This is a baseline issue like everything else in Washington. Relative to what people, what providers think they'll get if they just project out their current revenue streams. It's going to be worse. Relative to what's most likely to happen which is a line that goes like that, it could be better.

ED HOWARD: Okay. Well I'm optimistic that we have just heard one of the best discussions of these issues that we're going to hear in this context. Thanks to all four of our sponsors for their support of this series. Thanks to you for being faithful to the cause. We've got another program on Friday on the uninsured you might want to check it by the way and in a small commercial there. And please join me in thanking our panel for a terrific discussion. [Applause]

[END RECORDING]