Raising Medicare's Eligibility Age: A Complex Proposition
Alliance for Health Reform
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ED HOWARD: My name's Ed Howard. I'm with the Alliance for Health Reform, and I want to welcome you on behalf of our board of directors and our honorary leadership, senators Rockefeller and Blunt to a program about proposals to gradually increase the age for Medicare eligibility from 65 years to 67. Now, it's a topic that's been under discussion for a long time. Back when I was on the staff of the then existent House Aging Committee this was a topic that came up from time to time. It's particularly coming up now, of course, in light of the ongoing rise in the age for full social security benefits from 65 to 67, and of course it's front and center in the current discussions about how to curb the federal deficit and avoid having us fling ourselves over the so called fiscal cliff in a couple of weeks.

We're trying to sort out the plusses and minuses of this proposal, which we find is more complicated than one might imagine, and it's complicated further by the shifting landscape of Medicare policy, federal health policy in light of the affordable care act, and the state of the health care system generally, hence today's program, and we're going to take a close look at some of the pros and cons with the help of some of the country's leading Medicare and retirement policy

We're pleased to have, as a partner in today's program, the Kaiser Family Foundation, leader in health care policy analysis and health journalism and communication, and we're especially happy to have, as the co-moderator today, Tricia Neuman, who's the senior vice president of the Foundation and a director of its program on Medicare policy, and I have a quick note for you. If you are watching live on C-SPAN or for that matter watching the webcast, which will be available beginning sometime tomorrow, you can find copies of the materials that have been handed out to those in the room, including copies of the slides that the speakers are going to use, and Tricia will be using some slides as well, on allhealth.org and kff.org. So follow along if you care to and have the requisite technology in front of you.

Tricia, thank you for being with us, and thanks for cosponsoring this event.

TRICIA NEUMAN: Thank you, Ed. It is great to be here, and I'm thrilled that we're here to talk about a topic that seems to be front and center. This has been an issue, as Ed said. Raising the age of eligibility has been talked about for many, many, many years, but it seems to be on the front burner today. I guess we could call it an on again, off again, on again, off again proposal, but it's not really clear where it

important that we are all here to understand what the policy means and what the potential implications can be. I'm just going to briefly set up the remarks from our colleagues, if I can.

ED HOWARD: To the left, try the left.

TRICIA NEUMAN: Could I have the first slide? Great. Okay, so the idea of raising the age of eligibility is certainly something that is on the table. It has been talked about sort of in conjunction with raising the age of eligibility for social security which was done many years ago. Why is it on the table? Well, I think the most obvious answer is because that it would be a source of savings for the federal government and for Medicare. The Congressional Budget Office, when they last looked at an option, said that it would reduce Medicare spending by 113 billion dollars over ten years if the age of eligibility was phased in over time the increase. By the way, the savings would be considerably higher if it were not done in an environment where the health reform law was passed and included spending for subsidies for people in the exchange and the cost associated with low income people who would shift to Medicare.

Prior to the health reform law when people talked about raising the age of Medicare eligibility, the big issue on the

lose access to affordable coverage and may not be able to get health insurance coverage at all? With the health reform law now about to be implemented, the discussion has changed somewhat since the health reform law does provide avenues for people to get health insurance coverage.

There are a lot of unanswered questions. The Supreme Court decision and the flexibility that it has given states raises questions about whether low income people throughout the country who are 65 and 66 will be able to get Medicaid in every state. This is a great example of a policy that seems very straightforward for Medicare. Medicare saves money with fewer people on the program, but I think as you will hear, this policy has ripple effects across the health care sector, and I'm really looking forward to our panel discussion so we can learn more about what the effects might be.

ED HOWARD: Great, thanks very much, Tricia. Quick logistical notes, there are lots of materials in your packets. Those are part of what is on a one-page list of materials that is available on our website that's much more extensive. I call your attention also to the blue evaluation form, which we hope you will fill out before you leave to help us improve these programs and cover topics that you would like to see us cover, and when we get to the Q and A, there is a green card in your

packets you can write a question on as well as to use the microphones to ask the question orally.

So let's get started. We do have, as I said, some terrific panelists who will give us some brief presentations, and then we will get to an extensive inter-panel conversation and Q and A, and we're going to start with Dr. Juliette Cubanski, who's the associate director of Kaiser's Medicare Policy Program and a main author of a whole series of analyses looking at proposals to reshape the Medicare program. See, for example, the pretty blue monograph in your packets on raising the Medicare eligibility age. Juliette, thanks for being with us.

JULIETTE CUBANSKI: Thank you, Ed. There we go. Is that better? Thanks, Ed, and as Ed said I'm Juliette Cubanski. I am associative director of the program on Medicare policy at the Kaiser Family Foundation. Tricia gave you a pretty nice precise overview of the option to raise the age of eligibility for Medicare. So I'm going to dive right in to the results of a study that we at the Kaiser Family Foundation conducted with colleagues at Actuarial Research Corporation to analyze the effects of raising the age of eligibility for Medicare from 65 to 67 if the proposal was fully implemented in 2014.

Sorry, can I go back? So we assumed full

the full year fully implemented effects in the current budget window, although most of the proposals to raise the age of eligibility would actually phase in over time. Our study is the first to look at the effects of increasing Medicare's eligibility age in the post ACA era, and that's important because it, to some extent, alleviates the concern that Tricia mentioned that people who lost their eligibility for Medicare would lose access to health insurance entirely because under the health reform law they would have access to new sources of coverage.

So our study also goes beyond some of the other analyses to look at the effects of raising the age of eligibility not just on federal spending and on Medicare spending but also on state spending, on out of pocket costs for the 65 and 66 year olds who shift out of Medicare, on employer costs, on costs for Part B premiums for people who remain on Medicare, on the exchange premiums for younger enrollees as well as the total health spending effects of all these changes across all the different payers.

We estimated that about five million 65 and 66 year olds would be affected if this proposal were implemented in 2014. We assumed that all would have coverage from another source if not from Medicare, although the Supreme Court's

decision to make the Medicaid expansion option calls this assumption into question to some degree.

In terms of the distribution of those beneficiaries who are affected by this proposal, as you can see on this slide, 42-percent would be expected to receive coverage from an employer, half from retiree plans, and the other half as active workers or spouses of active workers. 20-percent would be covered by Medicaid including those who would have been covered by both Medicare and Medicaid as dual eligibles as well as those who would qualify because they have incomes up to 133-percent of poverty who would qualify for the new Medicaid expansion, and just about 40-percent would receive coverage through the new exchanges.

In terms of the effect of raising eligibility age on beneficiaries' out of pocket spending, the direction and magnitude depends on a number of factors, including whether people would be covered by Medicaid or whether they would receive subsidies for coverage for the exchange. Our analysis takes into account all of the expected costs that 65 and 66 year olds would have faced if they were enrolled in Medicare, including their Medicare Part B premiums and premiums for supplemental coverage they may have had, and their out of pocket costs for Medicare covered services, and then their

expected premiums and cost sharing under other sources of health insurance in lieu of Medicare.

Our analysis shows that about two-thirds of the five million are estimated to pay more as a result from shifting Medicare to another source of coverage. On average about $2200 more, and one-third are estimated to pay less under their new source of coverage than they would have paid out of pocket under Medicare, on average about $2300 more.

The one-third who are projected to have lower out of pocket spending include people who would qualify for the Medicaid expansion and those with relatively low incomes who would qualify for more generous subsidies through the exchanges. The group that we estimated that would save the most is an estimated 860,000 new Medicaid enrollees, those with incomes below 133-percent of poverty.

The two-thirds who are estimated to have higher out of pocket spending include people with incomes above 300-percent of the federal poverty level who receive either less generous subsidies or no subsidies for exchange coverage and those with employer sponsored insurance. The group the bears the largest increase we estimated to be roughly one million people with incomes above 400-percent of poverty who receive coverage under the exchange.

So now I want to shift to the impact on federal and state spending and the effects on spending by other payers. Net Medicare savings we estimated to be about 23 and a half billion dollars. This is a savings from not paying costs for those 65 and 66 year olds who are no longer eligible for Medicare minus the premiums for Part B that those individuals would otherwise have paid.

In terms of the impact on total federal spending, the gross federal savings are estimated to be just over 30 billion dollars, but federal spending increases by about eight billion dollars for Medicaid as the low income 65 and 66 year olds shift to Medicaid coverage by about 9.4 billion dollars for the exchange for subsidies for those who shift out of Medicare and qualify for exchange subsidies. There's a revenue decline from the Part B premiums that are no longer paid by these 65 and 66 year olds. So on net our analysis suggests that federal spending is estimated to decline by 5.7 billion in 2014.

In terms of out of pocket costs we estimated higher net out of pocket costs as a result of this policy partly due to an increase in Part B premiums paid by people ages 67 and older who remain on Medicare in 2014. This is because you're removing the relatively healthy 65 and 66 year olds from the Medicare risk pool so that risk pool gets a little bit sicker

the premiums paid by those under age 65 who purchase coverage through the exchange because we're shifting the lower cost 65 and 66 year olds out of Medicare and into the exchange.

We estimated employer costs would increase by about four and a half billion dollars, which results from employer plans becoming primary rather than secondary payers wrapping around Medicare. Now that Medicare's no longer the primary payer, they become primary.

We estimate total premiums would increase as a result, which would increase costs for employers and retirees, each of whom are expected to pay about half of the higher premium total. State Medicaid spending is estimated to increase by just under a billion dollars in 2014. This is mainly a combination of increased spending on Medicare Part B premiums for the dual eligibles ages 67 and older since, as I mentioned, raising the age of eligibility is estimated to increase the Part B premium for Medicare enrollees, and then there are state savings associated with not paying Medicare premiums for those ages 65 and 66 who would have been duals.

So when you add it all up, the bottom line from our analysis is estimated net federal savings of 5.7 billion dollars but net increased cost of 11.4 billion dollars to other payers for a net result of 5.7 billion dollars in increased

the age of eligibility for Medicare, if fully implemented in 2014, would reduce Medicare spending, although less than previously estimated because of the new costs of providing subsidized coverage to those who qualify for the exchange coverage or Medicaid.

It would reduce out of pocket costs for 65 and 66 year olds with relatively low incomes while increasing costs for others including the majority of those ages 65 and 66 with incomes above 200-percent of poverty, adults younger than age 65 in the exchange, and seniors and people with disabilities who remain on Medicare.

So our analysis really underscores the importance of carefully assessing the distributional effects of Medicare reform proposals like raising the age of eligibility. Clearly savings to the federal government is an important goal in current discussions, but within health policy circles, of course, a lot of attention is also being focused on keeping our eyes on the prize of lowering health care spending overall, which our analysis suggests is not achieved by raising Medicare's eligibility age. So with that I'll turn it back to Ed.

ED HOWARD: Great, thanks very much, Juliette. Now we're going to turn to Gail Wilensky, who has no slides. So we

senior fellow at Project HOPE. She's also a former Medicare administrator, a former healthy policy to the president, one of America's most respected health economist and I'm pleased to say a frequent contributor to Alliance programs. Gail, thanks for joining us, today.

GAIL WILENSKY: Do I have to –

ED HOWARD: You should see a red light.

GAIL WILENSKY: Okay, thank you, Ed. I'm delighted to be here. I'm going to try to make four or five points quickly and look forward to the discussion. I found the analysis, as we just heard Kaiser Family Foundation has done, very interesting in looking what they see as the likelihood of what would happen if the increase in eligibility were to be instantly implemented in 2014, although as has been indicated that is generally not the proposal, and while I appreciate the qualification, I think it's important to understand there was on assumption that was never made, and that is that there would be any behavioral change as a result of the change policies.

For many of us who support the notion of increasing the age of eligibility for Medicare, and I'm going to qualify it in a minute, it would be within the context of part of a set of fiscal policies that need to be enacted in order to encourage individuals to change their vision of appropriate retirement

19th century to something that is more reflective of the increased longevity that has occurred and that needs to be consistent with the way to make it easier for people to stay in the labor force longer. Obviously this is something that would occur over time and not indeed be instantly put into effect in 2014.

You have in your packet a piece I wrote earlier in the year where I articulated what I thought were emerging elements of bipartisan agreement of ways to try to reform Medicare. What a difference an election makes. It was earlier in the year regarded by none other than the president as an element that should be considered as a way to try to reform Medicare. Times do change. It makes it less likely now with the political shift, but I think it still remains an important issue to consider, and let me explain what the pros and cons as I see.

First, it is not a panacea for Medicare. Yes, the 65 and 66 year olds are healthier than the average Medicare individual. CBO estimates, as you have heard, range somewhere between the 113 and 130 billion over ten years depending on when the estimates have been made. Nonetheless part of a strategy to try to encourage people to stay in the labor force longer, but not the only one for sure, it makes sense. Why is

in longevity, when social security was adopted in 1935 and neither men or women lived to 65. When Medicare was adopted in 1965, men were living slightly more than 65, lessens to 67, and women almost to 74. There's been an increase since then, and we're now talking high 70s for males and into the 80s for females. That is not uniform. I understand that.

I'm speaking tomorrow at a NIH conference on finding ways to reduce disparities, but it is clearly true in general, and what we need is to try to find ways to try to encourage people to participate in the labor force longer, not only for our sake but for their sake as well, being contributors to rather than net takers from the public fisc. It will require a number of changes. This one, if done carefully, could be one such component.

Second issue is that Medicare has a serious long-term problem, one that is not likely to be resolved only by increased financing. As most of you know there will be a doubling of the population when the baby boomers finish retiring. That is associated with moving from all entitlement spending of about ten-percent now to more than 15-percent of the GDP in 2030. That is an indication of a very serious change that we are going to have to look going forward.

Now, some people have commented that Medicaid spending,

looking pretty good. The growth in Medicare spending has been officially projected as a result of the affordable care act to grow at about the rate of the economy, but of course we all should recognize that what we are seeing are the results of projections that incorporate Medicare's paying the providers of services less not Medicare costing less. This is a really important distinction. Paying less isn't the same as services costing less. In fact, it is one of the reasons that the Medicare actuary has repeatedly said in public that he questions whether the accumulation of reductions in payment will be able to be sustained because without a real reduction in their cost it will lead to access problems, and at least historically reductions in payments have not been sustainable in Medicare for that very reason.

They are promising changes that could be implemented Medicare result of pilot programs or things going on in the private sector, but right now we need to recognize that what we are observing are reduced payments for Medicare, not reduced costs for Medicare. So that is an issue that will continue to have to deal with.

What we really need to consider is how can we implement, if we want to implement, such programs in a way that recognizes most individuals can work after the age of 65,

experiencing disability and therefore would not be able to work. One is to have a differential allowed so that people who are not able to work because of disability would qualify for Medicare, as it exists now. To some extent that already would exist as default because of the SSI provisions that allow for people to go on to Medicare as a result of disability.

There's another interesting concept that Zeke Emanuel raised last May of talking about whether or not raising the age of eligibility to correspond to lifetime wealth is something that ought to be explored, and the idea there is to say that people who have had higher lifetime wealth would be expected to join Medicare and perhaps social security at older ages than people who have had low amounts of lifetime wealth for whatever reasons.

The issue really is to recognize that the stress that we are going to see going forward in the Medicare program, particularly after the end of this decade even given the assumption that all of the currently legislated reductions in the Affordable Care Act actually occur, is going to put enormous pressure on introducing change into the system, and one is, as I've said earlier, that will be very hard to accomplish simply by raising the financing, trying to decide what those changes are that make sense, allowing ourselves a

over the course of five or ten years, signaling people who are going into retirement that they should have different expectations about the program that they will face would be enormously helpful.

Unfortunately that has not been our strong point, and as I have been commenting for the last several years I don't know that the country is ready to consider in a major way entitlement reform right now or in 2013, more appropriately, for a simple reason, and that's because we don't have to right now. Whoever has the fortune or misfortune to be elected president in 2016, and speculation has already started I've noticed, is not going to be able to delay it any longer if we go that far because of the accumulated effects of baby boomers on retirement, but it sure would help if we could make up our mind about what we're going to do to make Medicare sustainable over the long haul at least the next couple of decades.

Thank you.

ED HOWARD: Thank you so much, Gail. We're going to turn next to Dave Certner, who's the legislative counsel for AARP and director of AARP's legislative policy for government affairs, and he does have a slide or two. Dave's an attorney by training with a rich background in retirement benefits, among other things, and he's been at AARP long before it became

DAVID CERTNER: Thank you, and thanks very much for Kaiser that did some great work, and I'll refer to some of their numbers as well, but first I wanted to start by just telling about who the Medicare beneficiary population is because sometimes people think that this is a population that's much better off than it actually is.

So if we could take a look at this first slide, you will see that where beneficiaries generally stand from an income's perspective, and you can see from this slide that the median income for a beneficiary is basically a little bit under $22,000. Even if you go up to the 75th percentile, so three-quarters of all beneficiaries with incomes of $40,000 or less, many of those who are above that level actually have higher incomes because they are still working and have wage income.

So by and large the Medicare beneficiary is a very modest income population, and I think this is important to understand when we're talking about Medicare eligibility age because raising the Medicare eligibility age is at its very core is a large cost shift, and so we're asking somebody to pick up a lot more costs, and one of the folks we're asking to pick up a lot more costs are the Medicare beneficiaries who are 65 and 66 who are already at very modest levels of income.

Also, as you can see from the next slide, beneficiaries

spending. It's one of their largest costs for seniors. So the typical senior is already spending about 17-percent of their income on health care, and I know in talking with lots of our members and having talking to many members of congress, very few of them will come back and say that what they've heard from their constituents is that people don't think they're paying enough for health care. People already are paying a lot for health care in this country and particularly seniors. So when we're talking about a giant cost shift, it's just critical to remember who the population we're talking about, what their incomes are and what they're already spending on health care.

Another argument that we've heard is, well, we should maybe make social security and Medicare more similar, and therefore raising the Medicare age makes sense, but, of course, this argument really turns the whole issue on its head and doesn't make sense either because the social security age, while it is raised to 67, you can still get access to social security at age 62. So anybody who needs social security can get access to it with an actuarial reduction. So people who need the benefit don't lose the coverage. They can still get the coverage. So if we're really looking to harmonize, you actually would be talking about lowering the Medicare age because most people actually claim their social security

benefit. So by the time you get to 65, the mass majority of people have already claimed their social security benefit. So this is a significant difference between social security and Medicare. You can always get access to your Medicare benefits. This proposal would be to take away coverage from people who wouldn't be able to get it under the program.

More importantly though, when you think about social security versus Medicare, part of the reason that you're trying to talk about raising the social security age – and, again, this was done back in 1983, and we're still raising the age, which gives you a sense of the long phase in time that was originally set for this program. It's still happening almost 40 years later. The key distinction here is that you can delay getting social security if you're still working because you don't need social security. If you're still working and you still have income, then you don't need social security. You can put it off until later, but if you delay or are still working, you still need insurance. That need doesn't go away. It's a fundamental distinction.

If you're 65 and 66, you still need health insurance, and so where does that lead us? Well, that leads us to my final slide, which basically shows you, as the numbers we were talking about earlier, the difference in cost for somebody

employer provided system. The employer provided system costs a lot more than Medicare, and so by pushing people into a different system and out of Medicare, what are we doing? We're accomplishing raising health care costs, not lowering health care costs in this country, and the focus here shouldn't really be on how much the federal government is spending on health care. The really big problem is how much the country is spending on health care, and a generation ago, when I started working, we were spending about ten-percent of the country's GDP on health care. We're about to head to 20-percent of the nation's GDP on health care.

So more and more of the nation's dollar is going to health care, and that's the big fundamental problem we should be addressing, and by shifting more people out of Medicare into a more fragmented more costly system, we may be saving the federal government money, but we're actually making the underlying, the real problem, worse, which is that we're going to be spending more money on health care, and I thank Kaiser for their numbers on this because I think they show what really what's happening here by pushing people into different programs. Either you're pushing them into a Medicaid or the employer provided system, or, by the way, we didn't talk about the fact that CBO estimates it about five-percent or so would

people into a more costly system, and so we're not saving the country any money at all. In fact, we're costing the country money.

We're raising health care costs in this country, and when you think about the big debate we just had over health care, regardless of whether you support Health Care Reform Act, I think most people supported the underlying goals of the bill, which were we want to try to improve coverage in this country while lowering health care costs, and this proposal does exactly the opposite. It increases the number of people who don't have insurance, and it raises overall health care costs.

So to us it's a very simple and bad solution, and it's actually looking at the wrong problem. The problem is health care costs, and we're actually making health care costs worse, and so we reject this as a way to move. Now, Medicare as a program can certainly be made more efficient than it even is today. We think Medicare can do a better job, for example, with care coordination and with transitions between settings, and that's the way to make health care more efficient, to save money in health care, make people healthier and to cost less. By simply raising the age, we're simply telling people you're going to have to pay more for coverage, and by the way some of you won't be able to afford your coverage at all even those who

available for subsidies. The exchanges still permit three to one age rating. So people in the exchanges who are 65 and 66 will be paying three times as much as a younger person for health care.

So there are significant costs that we're shifting on to this population, and, again, I go back to the population we're talking about. We're talking about a population who has a median income of $22,000, and as Kaiser's numbers show, the average cost increases for people who are going to be seeing an increase are $2,200. So another ten-percent of their income would be going to health care.

Now, I suggest to you that for those people this is not really an affordable cost share, and particularly if we're talking it in a deficit reduction context and I think if we're talking about the fact that this is really not good health policy in this country, it just simply raises health care costs, so it's not really good health policy, but some will argue, well, we need it for deficit reduction purposes. We need to lower the amount the federal government is spending on health care, so this is an important deficit reduction policy, but what I want to ask you is it right to have this group of people, 65 and 66 year olds bearing these very large costs? Is this the group that you should be bearing a huge portion of

particularly fair shared burden to ask this group of people to be sharing ten-percent of their income in addition to going to health care costs. It's really not something that they can bear.

So for us this is a pretty simple equation. It doesn't make sense as a matter of health policy. It raises costs. It doesn't lower them. It actually increases the number of uninsured. It actually increases premiums for everybody else who remains in Medicare because you've now taken the youngest people and the healthiest people out of Medicare. So everybody remaining in Medicare, it doesn't just affect 65 and 66 year olds, everybody remaining in Medicare is going to see a premium increase estimated at about three-percent a year. When you move those 65 and 66 year olds into the private market, now you're putting the least healthy into that risk pool. You're making that risk pool worse, and everybody there is going to see your premium increase. So we end up with higher costs and more uninsured. It's a bad measure for health care in this country, and if we're looking at it from a deficit reduction perspective, we're asking people who have mean incomes of $22,000 to pick up a huge amount of additional costs. So from either perspective this, to us, doesn't seem like a good idea.

ED HOWARD: I think we got that basic point. Thank

the senior vice president for health care reform at the American Benefits Council. The American Benefits Council represents Fortune 500 companies that sponsor or administer health and retirement benefits affecting about a hundred million Americans, and Paul has also served in senior positions at HHS. He's done a stint here on the hill and is well positioned to offer us some comments about the proposal at hand. Paul, thank you for joining us.

PAUL DENNETT: Thanks, Ed, and thanks very much for the invitation to join you. For those of you who are taking notes, I'm going to make three points, and even if you don't, it may just lead to help you to understand where the sub points are going.

The first point is basically I want to talk about how all employers are not the same. So when we look about the impact on employers, we really have to look behind that in terms of which employers are we talking about. The second point kind of follows from the first point, which is the response among employers to a public policy change of this sort will also vary. It won't be the same. There will be different responses from different groups of employers, and my third point basically is that context here matters a lot, particularly to the same employers that typically would offer

So let's go back to their first point about not all employers are the same. I think one of the major contributions of the study that was done by Kaiser Family Foundation that Juliette walked through, or two things, one is that it's one of the first studies that takes a look at the post health care reform world and reminds us that that world changes a lot of the typical analysis that was done in the past about the effects of policy changes and the Medicare program, and you need to update all of your assumptions based on how people will behave in a post-reform world, and I think that was, in itself, a major contribution.

The other, though, was that it looks at a distributional effect of these types of policy changes. Well, when you look just at the employer community, I think it's really important to understand exactly where retiree health benefits are. There was a recent study in October of 2012 by the Employee Benefits Research Institute, EBRI, that found that no great surprise that the existence of retiree health benefits have been declining, and you can really mark the decline of retiree health benefits from 1990, which was the introduction of the financial accounting standards policy called FAS 106, which required employers to account for not just the present year liability for making commitments for benefits to employees

to their liability books in their current year. That had a major impact on employers' behavior because the biggest out year liability that they had committed to was in the health care side.

So since that time retiree health benefits have really been declining almost every year. Right now, according to the EBRI study done a couple months ago, there's only six-percent of employers overall that even provide retiree health benefits to employees. If you look at firms with over 1,000 employees, now you're beginning to look at where the benefit resides. It jumps up to over 30-percent of those firms, and actually if you took the number even higher, you'd really get at the kinds of firms in the private sector that still have a retiree health benefit, and those would be in industries like automotive, other large manufacturing, telecommunications, defense, and aerospace. Outside of some of these industry sectors, very difficult to find a retiree health benefit, and also among smaller or midsize employers it's basically now nonexistent.

So the effect, for most of us who would retire without retiree health coverage from most employers, certainly smaller or midsize employers or even large employers that don't offer the benefit, of a change in the Medicare eligibility age would largely be the extent to which that change encourages people to

work longer in their jobs, something that Gail alluded to earlier.

Is that a good thing, or is it a bad thing? Many employers are looking for older workers to stay in the workforce longer. For many individuals it's also going to be offset by the fact that, again, post-health care reform, post 2014, that there will be probably also individuals over age 50 or over age 55 who would no longer face job lock and who will be able to move out of employment because they're not as concerned about staying in until Medicare eligibility age and get coverage through exchanges or coverage through another employer. There's more freedom to move around than there had been before. So, yes, on the margin it will encourage some employees to stay in the workforce longer because health care typically is subsidized by employers if you remain in the workforce at 75 to 80-percent of the cost, and as Juliette pointed out and David also that many individuals, particularly those above 300-percent of the federal poverty level, will qualify for coverage but not for premium tax credits in the health insurance exchanges and so would be better off from just a health care subsidy point of view by retaining coverage through their employer plan, but that won't be true of everyone, and some people will leave earlier than they might

Secondly, the point here I wanted to make here is that the response among employers will also vary, and now we're just talking among those over 1,000 employee employers who offer retiree health coverage to their employees or their former employees. It's important to know that in many cases there are really two different ways in which an individual who retires prior to the age of 65, what the duration of that coverage will be if they're fortunate enough to have it from their former employer. One is that the coverage ends at the time that they become eligible for Medicare, and that's what their contract reads. That's the commitment that has been made. So if the public policy is that that age of eligibility changes and goes further out, so would their health care coverage. However, others are in coverage that says that it ends at the time that they reach the age of 65, since that was a proxy for Medicare eligibility age.

In that case those individuals would presumably get coverage on the exchange until such time as they become eligible for the now delayed eligibility date for Medicare. Either way, but particularly for those employers that would have policies that are written to say that it continues until the age of Medicare eligibility, they're going to need time to conform to any change of this sort. They can't just change

of the things that is true among employers generally that offer retiree health is they're looking for a way to harmonize their strategy between their post-65 retirees and their pre-65 retirees.

Right now what most employers who offer retiree health do for those who are Medicare eligible, it's essentially a defined contribution, a pot of money given by the employer to allow those individuals to shop for health care coverage and an exchange just for Medicare beneficiaries, which is really about choosing Medicare advantage plans or a prescription drug plan with finances that are provided by their former employer. Employers have already been looking at the possibility of doing something very similar to that for their pre-65 retirees, and the availability of coverage through the exchanges may well give them that same ability anyway. In order to move pre-65 retirees into a strategy where instead of the employer sponsoring a plan for retirees and having them continue on in the employer's plan, they'll simply provide financial assistance to the plan that an individual may choose on their own, either through a public or these emerging private health insurance exchanges.

In an October 2011 study done by Towers Watson, a large benefit consulting firm, they found that only a small

realistic strategy, at least as of 2011, to move employees into health insurance exchanges as they're developing come 2014, but many more, close to 40-percent of those same employers, thought that it was a very viable strategy to do so for retirees. So a change in the Medicare eligibility age may well hasten the change from being a defined benefit plan sponsor for retiree health among employers to more of a defined contribution strategy, again something that employers are already doing for their post-65 retirees in many cases, and then finally the point that context matters, and we've heard a lot about that already from the rest of the panelists.

This won't be a change in all likelihood that comes up in isolation on its own. We already know that it's being discussed as part of the negotiations between the speaker and the present over possible ways to avoid the fiscal cliff. Large employers, very actively, are up encouraging those negotiations to succeed. It's very important from the health of the overall economy that those succeed, or it could come up as part of entitlement reform, which Gail thinks may not occur until 2016 or behind but could come up sooner or possibly even as part of a broader negotiation over tax reform. So you really have to look not just at the possibility of a change in the Medicare eligibility age but the broader context in which

Thank you, Ed.

ED HOWARD: Great, thank you very much, Paul. Excuse me. Get to the point where we can hear your comments, hear your questions. There are green question cards you can fill out and hold up. Someone will bring it forward. There are microphones on either side of the room that you can line up behind to ask your question, and I know Tricia's been scribbling questions right and left as we were going through the presentations. Do you want to start us off? No?

TRICIA NEUMAN: Sure. One of the ideas that Gail mentioned that has been put on the table is one by Zeke Emanuel that would apply a lifetime earnings test so that wealthier people would have a delayed eligibility age, and so I guess my question, as a former administrator involved with social security and Medicare and IRS maybe, what's involved in making that happen, and do you think that's a viable option, and then what would happen to the savings that would be associated with the proposal?

GAIL WILENSKY: I haven't seen how Zeke proposes to define lifetime earnings. Anything that goes beyond current income, which the IRS is very good at calculating, becomes very complicated, and anything that attempts to define wealth, including assets, is very complicated. Something that looks at

because that is already available to social security and could be calculated. So it will depend on very much on how it is done and how it is phased in. Any of these changes are assumed to be phased in because it's unfair to change the rules drastically for people who are into retirement or very close to retirement. It is really of signaling to people who are in the labor force, that no surprise to many of them if you ask them they're expectations, that the entitlements as they have existed are going to change for them, and the sooner we can decide what that package looks like so that they can plan their response, the better off we'll be.

Really, again, if you assume no behavioral change, this doesn't look particularly attractive. It is all about trying to put together a package of fiscal policies that begin changing the expectation that a number, that was somewhat arbitrarily chosen in the late 19th century and that remained pretty irrelevant even through the starting of Medicare as in age, is no longer irrelevant at all, and with every expectation that we'll continue to see increases in longevity, very long periods in retirement as we now define it.

ED HOWARD: David

DAVID CERTNER: I think it is worth adding to that that talking about Medicare being based on lifetime income ignores

Obviously there's no income cap right now on the payroll tax cap as there is in social security. So you pay payroll tax based on all your income. There's an income related premium for Part B. There's an income related premium for Part D. You have portion of your social security tax goes to Medicare. Now there's an additional tax on unearned income above $250,000 that goes to Medicare. So Medicare is a heavily income related program right now, and, in fact, I can't imagine that people on the higher end are getting anywhere close back out of the Medicare program to what they've been contributing to it over their lifetime.

ED HOWARD: Alright, we have someone at the microphone. I would ask you to identify yourself and keep your question as brief as you can.

BOB ROYER: Yes, Bob Royer, British Medical Journal. Most of the talk has been about the impact upon the federal budget and balancing one pocket versus another. What analysis has been done on, say, these changes on the impact of the employability of seniors if an employer has to carry these additional costs for an extended period of time? My hypothesis would be is that it would make them less employable in some ways, either that or hasten the flight away from employers even providing insurance. Then on the consumer side, how would

these increased costs affect access to care and its probably quality of care?

ED HOWARD: Paul, do you want to start the first part of that?

PAUL DENNETT: Sure. On your first question I've actually not heard anyone or any of the studies suggest that extending the Medicare eligibility age would hasten the point at which employers might not offer coverage at all. What I was trying to indicate earlier is that for the vast majority of employers outside of the industries where retiree health might be highly concentrated, the effect of the Medicare eligibility age would be that at the margin there'll be some employees that would continue in the workforce longer because the subsidy they receive from their employer would exceed the subsidy that they would receive if they got it on their own through a health insurance exchange. Indeed they might not qualify for one at all, but it could also be offset by individuals who no longer have job lock who go out and do independent consulting or go work for a nonprofit where they don't provide health care coverage because they can now get coverage through health insurance exchanges.

Post-reform it eliminates one of the reasons that you had older workers remaining until Medicare eligibility age,

any other source. Now it becomes an affordability question since it will be available through the exchanges.

ED HOWARD: Dave, you want to talk about the consumers?

DAVID CERTNER: Well, I think we just heard a little bit about what the consumers will end up going into different pots, and I think particularly from our perspective we know that it's just going to cost the individual a lot more, perhaps a couple of thousand dollars more, and that, of course, will lead to the fact that some people just simply won't be able to afford it, and we'll end up with hundreds of thousands of more uninsured at the age of 65 and 66.

We also know what happens to people now who are 63, 64 who don't have health insurance. Many of them, and we hear from them all the time, are basically saying they're just hanging on until they get to Medicare eligibility age hoping they won't have a major event. They end up not getting health care during the time period, and of course we know what happens to people who don't get the health care they need. They end up getting onto the Medicare program much sicker and then costing the health care program even more. So I think it's pretty clear that when people have coverage, we can keep them healthier, and we can do something to save costs in the long run as well.

We just saw the CBO do a study just this past month on the prescription drug benefit where they basically rescored the program as costing a lot less because they discovered that basically when people are getting the medication that they needed, the health care costs tended to be a lot lower, and so the score went down for the prescription drug benefit. I think you'll see the same thing here. The more uninsured you get, the more costs are being shifted off onto somewhere else, and people are going to be sicker. Therefore the costs will be even higher.

GAIL WILENSKY: But that is the point now that you have the ACA that you can have this discussion in a way that was much harder to have before. It is really of saying for those who are able to continue working, can we begin to reorient the expectation for the next generation, which is what we're talking about, recognizing that for people who are in that now pre-Medicare age they will no longer have to postpone taking care of health care because they, in fact, have an option. So it is why this discussion takes on a whole different tone as a result of the Affordable Care Act having been passed.

DAVID CERTNER: I would say that we have options, but we don't know if they're affordable options, and that's really the big difference.

AL MILLIKAN: Al Millikan, AM Media. What can we learn from other countries? I'm wondering if any of you have studied the health benefit programs elsewhere, and do any have comparable insurance programs, and what has been the experience in other nations?

GAIL WILENSKY: Most of them are struggling mightily with the promises they have made, which encourage people to retire even earlier than they do in the United States and are finding themselves in very significant fiscal problems. France has to be the poster child of all, although maybe Greece, I guess, would take number one.

DAVID CERTNER: But we do know that the U.S. spends a larger percentage of its GDP on health care than any of the other developed nations by a fairly significant amount. So really tackling that underlying issue of what percent of our economy is going to health care in general is really the key issue, and we should be focused on that much more than the federal government's portion of it, and in this case where you have a proposal that would actually increase the share of GDP going to health care is taking us in the wrong direction.

GAIL WILENSKY: That is assuming that Medicare spending equal Medicare costs, and, again, as somebody who actually ran the program, I'm not assuming that.

TRICIA NEUMAN: David, this one is definitely for you specifically and AARP. The question is this. What scorable savings proposals does AARP support for Medicare beyond just better care coordination? Does AARP support means testing, combining Parts A and B cost sharing, or Medigap reforms or anything else?

DAVID CERTNER: I think it's important to remind everybody that we recently had a large health care bill called the Affordable Care Act, which included 720 billion dollars of Medicare savings, which I'm sure many of you heard throughout the year as both candidates talked about it. So it's not as if we have not contributed a significant amount of savings in Medicare already. We still think we can do more in terms of Medicare to make the program more efficient, less wasteful, to focus more on quality of care. There are a number of strategies around that. There are no silver bullets because these don't just apply to Medicare but to health care in general, and it is really about making the health care delivery system more efficient, and that means a better job of care coordination, a better job of transition between settings, a better job of using evidence based medicine, a better job of using health information technology.

Certainly going after waste and fraud can help. We

are all different strategies to make health care more efficient and save money as opposed to the conversation we're having here today is how do we shift cost to another payer? We need to move away from that kind of a conversation and get to a conversation about how do we lower overall health care costs, not just how do we shift cost, and in this case shift cost and make the shift even larger than the amount we're saving.

ED HOWARD: Okay, got a question here that sort of tickles my bones because it channels my old boss Claude Pepper. Though some employers value 50 plus year old workers, the questioner writes many others offer incentives to reduce their older workforce and/or are reluctant to hire workers 50 years and older. Could the panel speak to the effect of this dynamic on a potential increase in the Medicare eligibility age?

GAIL WILENSKY: As many of you know there is an expectation of problems stemming from the baby bus generation and lower cohorts entering into the labor force in the future. It is why many have thought potential for having older workers be increasingly regarded as valuable is highly likely, and one of the questions that is raised is can the federal government help begin to craft a set of fiscal policies that recognize the increased flexibility that many older workers will want and to try to make accommodations.

Because of how long I've been doing this I'm finding it hard not to think this sounds hauntingly like the questions posed about whether or not employers would hire women during childbearing ages that came up in the 1970s and how would they make those accommodations, and both the additional demand for such individuals in the labor force and the willingness for working women to continue to work has made that now seem rather quaint and old fashioned, and I suspect in the course of the next decade, as we come out of our current excess supply of workers and go back to a more normal period, older workers will become increasingly desirable, and employers will have a lot of reason to try to keep them in the labor force, especially if we can make it a bit easier for them.

DAVID CERTNER: And I think we would certainly agree. We would like to encourage people who can work to work longer, but our observation at the current time is that employers' demand for older workers, and there has been an uptake in the number of older workers over the last 20 years, but the demand is usually for higher skilled, which tend to be better paid workers who employers demand to keep or maintain in the workforce and not as much so for lower skilled, lower paid workers, and an interesting point that goes along with that is if you look at increases in longevity, you will see a very

people who are higher income and people who are lower income. The significant gains in longevity have really been made among higher income individuals, and particularly at the lower end longevity gains for the last generation have been very flat.

ED HOWARD: Paul, you had a comment?

PAUL DENNETT: I would just build on the comments from both Gail and David that I think we are seeing a shift for employers valuing older workers. That's definitely been something that I've seen over the past 15 or 20 years too that there's more recognition of the importance of maintaining your talent for longer periods of time, and if anything, one of the first things I think that employers identified as a concern about the availability of subsidized coverage in health insurance exchanges is that it might encourage some of the workers who they want to remain in the workforce longer to leave sooner than they might otherwise.

So I think that's just one of the realities and, as I started out with my comments, I think one of the really big contributions that Juliette and Kaiser Family Foundation in general did with their study of really being one of the first that starts to look at the whole world and ask questions of how does this analysis of public policy change once you factor in the enactment of the Affordable Care Act and its implementation

TRICIA NEUMAN: Okay, this is a question for Juliette. So the Kaiser study estimates spending based on full Medicaid coverage. Everybody who is eligible for Medicaid it's assumed that a hundred percent would get coverage, so there are questions both about coverage and costs. Now the study is done, and we know what's going on in the real world. What are the more likely effects on coverage, and what are the more likely effects on Medicaid costs?

JULIETTE CUBANSKI: Okay, so I'm going to broaden this question a little bit to talk about the effects for all coverage sources. So we assumed, as I said, that everybody who lost eligibility for Medicare would take up another source of coverage depending on their access to other sources such as employer coverage or their incomes, which might qualify them for subsidies or for Medicaid coverage. So first let's take this question of the individual mandate and premium subsidies in the exchanges. There have been questions raised about what happens. If people 65 and 66 don't have Medicare, can they qualify for these? So there's no mention of a specific age for qualification for subsidies for exchange coverage, so presumably if people didn't have access to Medicare, they could, depending on their income, qualify for whatever subsidies they were entitled to.

It's a different story for the Medicaid expansion. The ACA specifically does limit eligibility for the new Medicaid coverage to people under 65. So presumably there would need to be a statutory change. If the Medicare eligibility age was raised to 67 or even higher, that provision would need to change to enable people to qualify for the Medicaid expansion. In states that done expand Medicaid those adults with incomes between a hundred percent and a 138-percent of poverty would be eligible for subsidies in the exchange, and they would be subject to the mandate, but for people with income below 100-percent of poverty in states that do not opt for the Medicaid expansion, they would not be eligible for Medicaid or subsidies in the exchange because the law limits those to people with incomes a hundred percent and above.

However, having spoken to my colleagues at Kaiser about this issue who have followed this issue more carefully than I have. Secretary Sebelius has said that these individuals would not be subject to any of the mandate penalties if they lived in a state that did not expand Medicaid and they fell into this coverage gap.

TRICIA NEUMAN: But then would they be uninsured?

JULIETTE CUBANSKI: That presumably would be the end result.

TRICIA NEUMAN: And so the question I really wanted to know how many people could potentially be uninsured?

JULIETTE CUBANSKI: Well, we don't really have an estimate since we didn't factor this. Our analysis was conducted prior to the Supreme Court's consideration of the case and the Supreme Court's decision, but I believe there was another analysis done of this issue, I think, by the Center for American Progress?

TRICIA NEUMAN: Center for Budget and Policy Priorities maybe?

JULIETTE CUBANSKI: I'm not exactly sure which, but anyway there has been some recent analysis of this question looking at numbers potentially for those individuals who are living in states that have expressed a lack of interest in expanding their Medicaid programs.

TRICIA NEUMAN: Okay, so while I have you at the microphone, there are a few other technical questions. One is, we assumed a hundred percent federal payments on Medicaid.

JULIETTE CUBANSKI: That's right.

TRICIA NEUMAN: Because it was implemented in 2014, and some have pointed out that there would be effects for states. Can you explain that?

JULIETTE CUBANSKI: Well, the state contribution for

percent federal share is until 2017, I believe, and then it phases down to 90-percent over the next few years. So states would pick up a slightly smaller – the effects that we found were net spending increase for states of 0.7 billion dollars, so not a huge number at least in the year of our analysis, but that would be a slightly larger number in later years of this proposal.

TRICIA NEUMAN: Can we do one more?

ED HOWARD: Yeah.

TRICIA NEUMAN: Okay.

ED HOWARD: Yeah, go ahead.

TRICIA NEUMAN: Okay, one more for you, and then we'll spread it out. Why are your numbers different from those of the congressional budget office?

JULIETTE CUBANSKI: Yes, okay, so CBO did an analysis of raising the age of eligibility. They also began implementation of a higher eligibility age in 2014. However, they modeled the phased in approach that most proposals incorporate and that we are more likely to see. So their analysis was over a ten year budget window, and ours was just in a single year of full implementation. There are some differences in the assumptions that they made in terms of they assumed that five-percent of this total population of 65 and 66

percent coverage, and there are some other slightly more technical differences in assumptions, but I think the largest one is the fact they were looking over a longer period of time and phasing in the proposal.

ED HOWARD: We've got a question here that asserts that several of the speakers have used average amounts in making their calculations but that significant differences are evident once you analyze different income groups, and although this questioner would ask this question of AARP, I think we'd be interested in hearing from other panelists as well. Since those below median income will be treated very differently, and I'm not sure that's quite right, from the average, what if the policy focused only on those in upper income? And that actually is a question that's been raised, for example, by Senator Durbin, who allowed is how he might be willing to consider a change in eligibility age if there was some way of protecting low income people. So I'd be interested in hearing how folks believe we ought to deal with that.

DAVID CERTNER: Well, I think a couple responses. One, the strength of programs like Medicare and social security is really based on the fact that they are social insurance programs that everybody pays into and everybody gets out of. Now, obviously I mentioned earlier about how the Medicare

there are some different income features throughout the Medicare program. Certain low income people, for example, have their premiums paid for through Medicaid. If you are in the Part D program and you're in the lower third of the income, you basically have more of your drug costs taken care of, for example. A lot of people in this room probably don't even know that for those people there is no doughnut hole because all their Part D coverage is taken care of. Those 65, 66 year olds may actually lose all that coverage should they not be eligible for Medicare.

So there are already a number of income adjusted features to the program, and of course there will be differences, as we've just heard. If there's Medicaid expansion in some states and not in others, then there's going to be a lot more uninsured in those states because those folks will not be able to afford their insurance. So we're already going to have a mixed bag of impact here, and we already do have a fair amount of income relatedness in the Medicare program.

ED HOWARD: Juliette

JULIETTE CUBANSKI: Can I just make one point on this? So it's a fair point. We're talking about averages, and we did look at the different income groups in our analysis. Granted,

percent or 200 or 300-percent, and then 400-percent and above is a large group, although it is a relatively small share of the Medicare population, but for those of you who are interested in looking at averages for specific income groups I didn't present them in my slides because I had a lot of material to present already in the ten minutes that I was allotted, but we do cover the different out of pocket changes in terms of premiums that people would have paid under Medicare and costs that they would have paid under Medicare and their expected premium and cost sharing obligations under Medicare or exchange coverage, and all of those results are described in more detail in the report that Ed held up for display at the beginning of our session.

ED HOWARD: Do you want to do that one? May I just say that these are some of the best questions coming from the audience that we've had in a long time. Thank you.

TRICIA NEUMAN: This question sort of speaks again to protections for the low income population, and has the option been discussed to modify the definition of poverty level to help lower income seniors if the age is increased in order to allow more seniors to qualify for subsidies, and more broadly as other cost sharing options are being talked about, are there options that are being talked about to provide greater

DAVID CERTNER: Again, I think there are already some protections for people who are lower income, but I think you're also dealing with a population that even modest income folks are really only between 20 and $40,000 is where you're going to have a lot of the people who are going to be having very heavy costs to try to go out and buy insurance in the private market or through the exchanges, and it's going to be quite a large chunk of money out of their pockets to try to be able to afford health insurance.

So sure, you could always adopt policies that help the lowest income, and there are some already policies in place that may help do that whether they're within Medicaid or within Medicare or pushing people onto Medicaid or giving people greater subsidies. You could change age rating, for example. Instead of having three to one, have it one to one. That would obviously help seniors. They could actually afford health insurance. So of course there are things you could do, but these things are obviously going to cost more money, and they're going to shift the cost somewhere else.

TRICIA NEUMAN: I actually think, now that I'm looking at it, the questioner might have been getting at something else, which is when people, once the health reform law is implemented, there will actually be more generous income and

the Medicare population for supplemental coverage. There won't be an asset test for Medicaid, for example, for people who are younger than age 65. So I actually think what the questioner is getting at is there some effort to kind of prevent that cliff from occurring in the context of some of these discussions, and I think the answer's no by the way.

DAVID CERTNER: I think the answer is no, and I think the answer is, of course, you could always spend more money to ease the cost on whoever group is being affected.

TRICIA NEUMAN: Yeah.

DAVID CERTNER: And that obviously just is additional money you'd have to come up with to try to deal with the problems you're creating.

ED HOWARD: And in the same vein this one actually harkens back to an earlier era as well, and the idea is that this is another policy proposal from one of you in the audience, which is to allow a buy in by those age 65 and 66 to the Medicare program if and as the age is raised for full eligibility, and it harkens back to a proposal in the Clinton health reform era of allowing people as young as 60 or maybe even 55 at one point to buy in at the full actuarial cost of the program. Any reaction to that by any of the panelists?

GAIL WILENSKY: It makes much less sense given the

been dealt with previously is that because there are individuals who, for whatever reasons, no longer have other sources of insurance coverage in their pre-Medicare years would it be okay to let them buy in on an unsubsidized basis to the Medicare pool? But we don't need to do that now because you have the Affordable Care Act, which will make insurance via either Medicaid or the exchanges available to people in a group setting, and you could think about technically doing it. It doesn't make a lot of sense.

PAUL DENNETT: Totally agree, and my first reaction too is such a proposal in today's context would actually make those individuals worse off unless you also brought over to the Medicare program the same set of subsidies that would be available to those individuals through the exchange.

DAVID CERTNER: Which is where the question was going. So if you bring over those same level of subsidies to an insurance product, which is lower in cost, to the point I brought up earlier about cost shifting to something that system wise costs more but it's less to the federal government by just taking them off, what if you offered a buy in to Medicare for the 65 and 66 year olds with the same access to subsidies through the HIE?

GAIL WILENSKY: You are assuming that it is actually

is that Medicare providers will be paid less, 1716 billion less over ten years as a result of the Affordable Care Act that is not the same as saying that Medicare is cheaper. There are various estimates which you can accept or not as to the kind of cost shifting that goes on into the private sector. There is almost nothing in the Affordable Care Act that actually lowers the cost of health care. There are a number of promising innovations that are going to be tried or that are in the process of being started by the Center for Medicare and Medicaid Innovations.

There are a lot of innovations being tried in the private sector that may end up actually lowering the cost of health care. Most of the components in the Affordable Care Act to date and those that are anticipated in the next couple of years will actually increase the cost of care because of the expansions that have occurred in terms of coverage and insurance reforms and because of the various taxes that have been tacked on such as the Insurance Premium Tax, the new fee that was announced for insurers who will be entering into exchanges, the Medical Device Tax. Those are all going to be passed on to the users. Now, that doesn't mean there aren't enormous potentials for figuring out how to provide care more efficiently in the future. We just have nothing now that

If we're lucky and figure out what works and then figure out whether it's scalable and then figure out how to actually make it a part of the Medicare program, all of that could change, but to date the lower payments that are estimated for Medicare over the course of this decade reflect lower payments to the providers of services, not lower costs of providing those services to Medicare beneficiaries. It's a really important difference.

ED HOWARD: Gail, is it fair to say that or did I understand correctly what you were saying to be that there really isn't a cost lowering strategy that's available now?

GAIL WILENSKY: The only small items that are actually in the legislation are, the ones that come to mind, the accountable care organizations, which are a shared savings mechanism. Interesting, we'll see whether or not they are actually a transitional model to something else and how many participate, but nobody expects large savings from the ACOs per se, and the introduction of value based purchasing initially to hospitals and then to nursing homes and ultimately to physicians assuming we ever figure out how to get out of the SGR box. Again, 300 billion dollars of quote, unquote savings that most people regard as even more ephemeral than other such types of savings.

If you actually look, other than the value based purchasing, which I support but is at the very edge of the tail that we're talking about in terms of change and the accountable care organizations, the promises for learning how to get out of the dysfunctional incentives of Medicare as we now know it, which is you get more income by providing more and more complex services, are tied up with these pilots. We all hope that we learn something and that there are changes that we can figure out how to introduce, but we're not there yet, and there are a lot of ifs that have to happen. So I applaud the Affordable Care Act for having substantially expanded coverage. That was very important. The hard stuff is yet to come. We haven't figured out how to do that. So as I look at the legislation there is precious little that lowers spending, and there are some things that increase costs because of the way it was financed.

DAVID CERTNER: I guess I would just comment that throwing 65 or 66 year olds into that market doesn't improve efficiency or lower cost either.

GAIL WILENSKY: No, and what I have said it is part and parcel of an attempt to try to get people to understand that the concept of appropriate retirement at, which made sense maybe at the end of the 19th century and 1935 and maybe even

longevity well into our 80s and for many people into our 90s, is a very old fashioned concept, and thinking about how to change that, not for those who are currently in retirement or about to be there but for the generations to come is really important, and this could be part and parcel in a way we really couldn't think about easily before we had the Affordable Care Act. Now, I've said, as one of my opening comments, this is not Medicare's panacea.

We've got some really serious problems to face with Medicare, and this isn't going to be it. It is really more as part and parcel of trying to recognize that the world has really shifted over the course of the last century, and I get to claim great appreciation, more than most on this panel, for having that happen, but we need to try to get this built into expectations for people who are currently working that this was an outdated concept a generation ago, maybe even two generations ago. It needs to be changed going forward.

DAVID CERTNER: I just have to say I think you miss the point when you keep talking about this being a retirement issue because regardless of whether a 65 or 66 year old is retired or working they still need health coverage, so it's really about a health care coverage issue and an affordable coverage issue, and that could happen either in the workplace or out of the

GAIL WILENSKY: But for people who are continuing working as an expected part of life, this becomes not much different than being 63 and 64. It is how you go into the mid 60 period when most people who report being retired are not retired because of reasons of disability. There is a group that do fall into that, and that's why we need to make some kind of accommodation either through existing disability programs or other, but the vast majority of people in their mid 60s can work. The expectation has been that this is a normal and reasonable retirement age, and it is one that is way outmoded.

DAVID CERTNER: Again, if they're working or not, they still need insurance.

GAIL WILENSKY: Yes, absolutely.

DAVID CERTNER: If it's costing more to be out of Medicare, then we're not really achieving anything.

ED HOWARD: At the risk of appearing to choose favorites about who gets the last word on this exchange, I point out that we have time for both of you to come back at it, and speaking of coming back at it, we have a second bite at the apple for Bob.

BOB ROYER: Thank you. Bob Royer, BMJ again. We're all familiar with the statistics that U.S. spends significantly

developed country. We hear that continuously. What I was surprised to hear at a recent conference was exactly the reverse is true when it comes to social support spending for lower income groups, for seniors and disabilities and things like this, which raises the question in my mind, would it be better for us to try and rebalance our spending in this direction to provide better quality of life by providing support services that allow people to stay in their homes functioning well instead of institutionalizing them, which is very, very expensive?

GAIL WILENSKY: We need to figure out how to spend more sensibly and efficiently in health care no matter what else happens because it makes no sense. We know it can be done in a smarter way. The question about how and how much kind of support structures is a very large one. I will say that most, not all, of the people who are now institutionalized in long-term care and other settings are there because they have multiple dependencies that are difficult to treat outside, that most of the people who were most easily able to be treated in the communities were moved out in a variety of programs in 1980s, 1990s. Some of the people on the panel, Ed Howard in particular, been involved with a lot of the work in terms of the channeling and other demonstrations that were shown to be

So I think it is somewhat of a misconception to think we have large numbers of people who are being institutionalized who can easily be treated elsewhere by trying to decide whether or not there's ways to change the mix is certainly fair enough. Whatever we do in other areas of spending we can find ways to have a more sensible health care delivery system. We're just struggling to figure out exactly what that looks like and how to get there.

DAVID CERTNER: And I think just one quick point, we basically can take care of three people in a home and community base setting than we can in an institution, and clearly that's the overwhelming preference is to be taken care of at home and not in an institution.

ED HOWARD: Okay, yes, and I might ask as you were getting ready to ask your question we're drawing down to the last few questions we'll be able to ask, so I would ask you to take this time to fill out the evaluation as you listen to the final exchanges. Yes, ma'am?

KIM CZUBARUK: Yes, hi. Kim Czubaruk, the American Academy of Nursing. It was just mentioned a little bit ago, how much has it been factored in, yes, Americans are living longer, but that's because of medicines keeping people alive, things like that. There's a very big difference between

well at all in life and being able to get up, commute, get to a job, stay there for eight to ten hours, commute back. So while, yes, we're living longer. It doesn't mean people are not suffering a lot with chronic conditions that really don't necessarily enable them to work full-time to really support themselves at a higher age, and how much has this really been studied, not just looking at the age we're living to but the quality of life and really people's ability to truly work full-time?

DAVID CERTNER: Again, there are a large percentage of people, either for physical or mental disabilities, cannot work beyond the age of 62. 62 is still the age of social security, which is the largest time when people claim, and so you're right. It's not just about their physical condition. It's about the availability of jobs, whether or not employers are trying to incent people in and out of the workforce. Many employees want to not work full-time, but they only want to work part-time. We hear a great desire for people to phase out so they don't just go from working 40 hours a week to not working at all. So all these things are changing right now in the economy. We do have, in some ways, healthier population we've ever had before, but we're also having a less healthy population we've ever had before with obesity and diabetes.

So what we do know, and I mentioned it earlier, is that there is a very significant difference in life expectancy based on incomes and that higher income people are really seeing significant gains. They're likely to, obviously, have more less physically demanding jobs that have better health care, and their life expectancies have been growing significantly while those at the low end have not.

GAIL WILENSKY: The direct answer to your question is there are people who are demographers that have looked at these questions, and there are surveys that are done that attempt to find out the answer as to whether or not people self report both in terms of their health status and in whether or not they retired because of reasons of disability, and so there is some information available. It is always imperfect, but it is not completely absence in terms of individuals and their ability to carry on daily functions as well as employability at various age spans.

ED HOWARD: Okay, yeah, go ahead. Why don't you go ahead and wrap it up?

TRICIA NEUMAN: Well, I think we're going to wrap up our discussion today. I don't know that we've come to any conclusion, but that makes us fit right into Washington on this topic. So we thank you all for coming. Before you leave I

timeline, that is going to be posted today on our Kaiser Family Foundation website. It's sort of a fun, quick way to get a little bit of history on Medicare. So for those of you who are looking for a fun way to learn about the program, I think you would find it educational, and it's short and brief, and I know everybody likes that.

So I want to thank Ed for hosting this discussion today and thank our panelists for coming and sharing your thoughts on this perspective, and I leave it to Ed for any final comments.

ED HOWARD: Only one thing, two things actually, one is to fill out those evaluations, and second is to manifest what Tricia was talking about by joining me in thanking our panel for this great discussion today. [Applause]. And for doing that so well, we're going to free you from the obligation to come to any more Alliance seminars this year. [Laughter].

TRICIA NEUMAN: Happy New Year.

ED HOWARD: That's right, happy New Year.

[END RECORDING]