Medicare 101: What You Need to Know

Alliance for Health Reform
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ED HOWARD: I'm Ed Howard with the Alliance for Health Reform. I want to welcome you. Thank you for coming. This is a program on the basics of Medicare and on behalf of Senator Blunt, Senator Rockefeller, our Board of Directors, I want to welcome you to this program, which we think is a pretty important one. It's sort of the building blocks of the rest of the congressional debate about Medicare. It's the largest federal health program in terms of dollars covering 50 million people at a total cost — a total cost this year approaching $600 billion. It was enacted back in 1965. I first came to work on the Hill in, are you ready for this, 1969 and I can't remember a single year since then when Congress hasn't done something important with the Medicare program. This a huge, a popular, an expensive program. It delivers healthcare to almost one in five Americans, particularly those over 65 and those with a disability, so there is a need for all policy makers to understand how Medicare works. There were some substantial changes to the program in the Affordable Care Act in 2010 and we'll hear about those changes as well today. Our partner and co-sponsor in this briefing, The Kaiser Family Foundation, it turns out some the best most understandable analyses of Medicare you're going to find, and the person who is responsible for a large part of that analysis is here today

to co-moderate this session and I am talking about Tricia Newman on my immediate left. She is a Senior Vice-President at the foundation and Director of the Kaiser program on Medicare policy and we are very pleased to have you and Kaiser involved in today's briefing. Tricia?

TRICIA NEUMAN: Thank you. Thank you, Ed. It is great to be here and I'm so glad so many of you are here for what we've sometimes called Medicare Boot Camp. We have some terrific speakers to provide a great overview of Medicare, how it works, who it serves, and some of the challenges that the program faces. I'm going to turn it over to them in a minute but first we have something kind of fun for you today. I hope it's kind of fun. We are going to do the Capital Hill release of a video that was prepared by my colleagues at the Kaiser Family Foundation which shows a history and timeline of Medicare. It's short, it's entertaining, but it provides a lot of information in a short period of time and so I think without further adieu we'll go right to that and with apologies that we don't have popcorn for you for the movies.

[VIDEO BEGINS 00:03:06]

ROBERT BALL: In the depression, the elderly were quite dependent on their sons and daughters and their sons and daughters were out of jobs.

PHILIP LEE: And the principle problem was medical care costs. Not that people couldn't get good care but it was that they could not afford it, particularly, they couldn't afford the hospital costs.

ROBERT BALL: There wasn't much of an argument about the need. The argument was what to do about it.

MALE SPEAKER: They thought it would help elderly people in the south but what happened was only 32 states had adopted it.

FEMALE SPEAKER: And what we found very clearly was only half the aged had coverage and most of it was very, very poor coverage.

PRESIDENT LYNDON B. JOHNSON: Our older people are three times as often to be hospitalized but their income is less than half that of people under 65.

PRESIDENT RONALD REAGAN: One of the traditional methods of imposing socialism has been by way of medicine. It's very easy to disguise a medical program as a humanitarian project.

PRESIDENT LYNDON B. JOHNSON: We wanted the world to know that we haven't forgotten who is the real daddy of Medicare.

MALE SPEAKER: The social security district offices were kept open into the evening for people who were still at work.

PRESIDENT RONALD REAGAN: I will submit legislation shortly to help free the elderly from the fear of catastrophic illness.

[Interposing]

WALTER CRONKITE: Once seniors and their drug costs exceed $2,250.00 they fall into the so-called Doughnut Hole.

PRESIDENT GEORGE W. BUSH: Now that the plan is in place, 39 million have signed up for it, drug costs are less than anticipated.

PRESIDENT BARACK OBAMA: We are done. [Applause]

PRESIDENT BARACK OBAMA: Beginning next year preventative care including annual physicals, wellness exams, and tests like mammograms will be free for seniors as well.

ROBERT BALL: A lot of care was given that would never have been given if it hadn't been for Medicare.

[VIDEO ENDS 00:09:59] [Applause]

TRICIA NEUMAN: Well that was a little bit different but we enjoyed it and also, if any of you think it would be helpful for your Congressional District Offices, or town meeting, or anything in that regard, we would be happy to make this available to you. It is a kind of a quick overview and a

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nice way of explaining things to people in a more entertaining fashion as you could. With that, I'm going to turn it back to Ed and the Alliance and thank you for having us.

ED HOWARD: Alright, thank you. There we go. If you want to take out your pencils now we'll give the test based on the film. Actually, we're going to reinforce the messages in the film we hope and some of the things that flew by pretty fast you're going to hear a little bit more detail about. A little bit of housekeeping before that. There are lots of good materials, many of them from our colleagues at Kaiser in your packets along with biographical information for our speakers, and the PowerPoint presentations for those who got them to us in a timely fashion. Some of you may be watching the web cast at this moment arranged with the support of the Kaiser Family Foundation as a matter of fact. You can find the webcast and a podcast probably tomorrow sometime at kff.org and also you can reach them through our website and get all of the background materials through allhealth.org, our website and there will be a transcript of today's discussion within a few days at our website as well. If you are watching on C-SPAN right now and have access to a computer, you can find all of those materials that the folks in the room have at their disposal in print form on our website at allhealth.org. At the appropriate time we'd love to have you ask a question. You can do that either by

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coming to one of the microphones or by filling out the green question card and before you leave we'd appreciate it if you'd fill out the blue evaluation form so that we can improve these programs for your edification.

We're going to hear from some very talented and well informed panelists today. They'll give some brief presentations and then we'll turn to your questions. Now you can't stump this panel so feel free to try, but also, don't hesitate to ask the most basic questions because we know a lot of you are very smart but very new to this topic and we want you to have a good grasp of the basics of Medicare which is the point of this briefing. We would ask you that you try to keep your questions aimed at the facts of the program or the background of the program and a little less about some of the policy disagreements that arise from time to time around this program.

With that, let me start on our panel. We're first going to hear from Juliette Cubanski who is the Associate Director of the Medicare policy project at the Kaiser Family Foundation. She's an expert on Medicare financing, she's an expert on the prescription drug benefit under Part D in particular, among other things. She has a doctorate in health policy from Harvard and her task today is to give us a broad

overview of this important program. Juliette, glad to have you back. Glad to have you set the stage for today's discussion.

JULIETTE CUBANSKI, PHD: Thank you, Ed. Thanks, Tricia. Good afternoon to all of you. As Ed said, I'm Juliette Cubanski, Associate Director of the Program on Medicare Policy at the Kaiser Family Foundation and my role here today is to provide you with a few essential facts about Medicare. I have a lot of ground to cover so let's get started.

As you saw on the video, Medicare was created about 50 years ago in 1965 to provide health insurance coverage to people age 65 and older. It was expanded in 1972 to cover younger adults with permanent disabilities. Today, Medicare covers about 50 million people, about 41 million people age 65 and older and 9 million people under age 65 with disabilities. Medicare covers people without regard to their incomes and without regard to their health status or medical needs and provides the same set of benefits to everyone who's entitled to Medicare. These benefits include hospital and physician visits, post acute care, preventative services, and a prescription drug benefit that is delivered through private plans, which have been playing an increasingly large role in the Medicare program in recent years.

Medicare covers a population that, on the whole, tends to be sicker and have greater health needs than others. Four in ten have three or more chronic conditions, nearly one-fourth have cognitive or mental impairment. The oldest beneficiaries, those ages 85 and older are 13-percent of all people on Medicare while the youngest, those under age 65 with disabilities are 17-percent. Many people with Medicare live on modest incomes that is derived primarily from social security and half have incomes less than about $22,500.00, which is about 200-percent of the federal poverty level.

For the majority of beneficiaries, Medicare benefits are provided through the traditional Medicare program. Benefits for hospital and physician services are divided into two parts, Part A and Part B. Part A is the hospital insurance program. This pays for hospital visits, skilled nursing stays, post acute healthcare and home health visits. Medicare charges a deductible before it begins paying for hospital stays. The deductible is about $1,200.00 this year and charges for each day of an extended stay in a skilled nursing facility or a hospital. Most people become entitled to Part A after paying payroll taxes for 10 years and enrollment is automatic when they turn 65 and you're on social security. Part B is the supplementary medical insurance program. This helps pay for physician visits, outpatient hospital services, lab work and

preventive services such as mammograms and flu shots. Most people on Medicare pay a monthly premium for Part B. This is about $105.00 in 2013 but this premium is income related meaning people with higher incomes pay a higher monthly premium. Part B services are subject to a co-insurance of about 20-percent and also subject to a deductible. Enrollment in Part B is voluntary, but most people who have Part A also enroll in Part B.

Part C and Part D are different from traditional Medicare because these benefits are delivered through private plans. Part C is known as Medicare Advantage. This offers an alternative to traditional Medicare where beneficiaries can enroll in a private plan such as a health maintenance organization or a preferred provider organization to receive their Medicare covered benefits. These plans receive payments from the federal government to provide enrollees with their Medicare covered benefits most often including the Part D drug benefit and often, extra benefits that Medicare does not cover such as dental services and vision services.

The Affordable Care Act of 2010 made some important changes to how Medicare Advantage plans are paid, which I think Jon will probably tell us a little bit more about. Suffice it for me to say that in recent years the payment system has driven a dramatic expansion of Medicare Advantage plan

availability and enrollment since 2006, which my colleague Gretchen Jacobsen at Kaiser has been monitoring very carefully. You can find lots of information on our website about Medicare Advantage plan availability and enrollment. Today about 13 million people, more than a quarter of Medicare beneficiaries, are enrolled in Medicare Advantage plans.

Part D is the drug benefit. It started in 2006. It's a voluntary outpatient prescription drug benefit delivered either through private standalone plans to supplement traditional Medicare or Medicare Advantage plans. Beneficiaries who want to enroll in Part D have more than 20 standalone plans to choose from in each state this year along with many Medicare Advantage plans. Plans are required to provide a standard benefit, which is shown here in Exhibit 5, but plans can vary the design of the benefit as long as it is at least equal in value and most plans actually do offer an alternative to the standard benefit. Beneficiaries pay monthly premiums and cost sharing for their drugs through Part D plans. If you've heard anything about Part D you may have heard about the coverage gap, which is also known as the Doughnut Hole. Beneficiaries had to pay 100-percent of their costs in the Doughnut Hole until they reached catastrophic coverage, but as a result of the Health Reform Law the coverage gap will be closed by 2020.

People with low incomes and assets are eligible for additional subsidies for Part D premiums and cost sharing and about 10 million beneficiaries are currently receiving this extra help and today about 90-percent of people on Medicare have prescription drug coverage, most through a Part D plan.

The cost of providing all of these benefits has risen along with rising healthcare costs and last year Medicare benefit payments totaled $556 billion according to the Congressional Budget Office. Inpatient hospital services comprised the largest share of these payments at 26-percent even though only a small share of Medicare beneficiaries are hospitalized each year, but hospitalizations are among the most costly services. This is followed by payments to Medicare Advantage plans reflecting the relatively large share of enrollees in these plans, then payment to physicians at 14-percent, and spending on Part D at 11-percent.

The money to pay for all of these benefits comes from several different sources. As you can see in Exhibit 7, Part A is funded primarily through payroll taxes, the big orange piece of the bar, which is a dedicated tax on earnings paid by both employers and employees. Part B and Part D are financed primarily through a combination of general revenues from the federal government, which is the dark blue pieces of the bars and premiums paid by beneficiaries.

Despite the important benefits that Medicare covers there are gaps in the benefit package. Traditional Medicare doesn't cover vision, it doesn't cover dental services, and doesn't pay for most long-term services and supports such as extended stays in a nursing home. Medicare charges, premiums and cost sharing including deductibles for Part A, Part B, and Part D that are indexed to increase each year all of which could be a burden for those who are living on fixed incomes. Along with the income related premiums for Part B and Part D, for individuals with incomes greater than $85,000.00 a years and couples with incomes greater than $170,000.00 a year, and unlike typical private insurance plans, Medicare does not place an annual limit on how much beneficiaries have to spend out of pocket for their medical expenses. Most beneficiaries have some sort of supplemental insurance to help with their out of pocket costs including employer sponsored retiree plans, Medicare Advantage, private insurance policies known as Medigap policies which help pay for Medicare's cost sharing requirements. About 9 million low-income Medicare beneficiaries also have Medicaid coverage, which helps pay their Medicare premiums and cost sharing and provides benefits that Medicare doesn't such as long-term services and supports and dental care.

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On top of all these benefit gaps and cost sharing requirements, rising health care costs are a real concern for beneficiaries whose out of pocket costs have been rising faster than their incomes in recent years. Medicare households spend about three times more than non-Medicare households on their health expenses. So all of these facts together could justify perhaps focusing some greater attention in the coming years on the adequacy of Medicare and on ways to bolster and improve the Medicare program. In the current fiscal climate the policy discussion around Medicare lately has been less about enhancing coverage and financial protections and more about ways to change the program to achieve savings. There have been several legislative efforts in the past few years that have taken steps in this direction. The Affordable Care Act of 2010 did include some benefit improvements including phasing out the coverage gap and eliminating cost sharing for prevention services, but it also included provisions designed to achieve major savings including changing the payment system for Medicare Advantage plans, changing payments to hospitals and other types of providers and ways to raise new revenues. The net effect of which is $716 billion dollars in lower Medicare spending over the next decade.

The Budget Control Act of 2011 calls for a 2-percent sequestration in Medicare spending which was temporarily put on

hold by the American Taxpayer Relief Act, which also put off a cut in Medicare payments to physicians. Sheila may be able to tell us what will happen next.

The message I want to leave you with is that while you may you hear that Medicare faces some serious long-term financial challenges, it's also important to remember that Medicare is a vital source of financial and health protection for 50 million Americans. It's a very popular program, and so moving forward it will be critical to understand the implications of proposed changes to the program for current and future beneficiaries.ED?

ED HOWARD: Great. Thanks very much, Juliette. Next, we welcome back to our dais the director of the Medicare Center within the Center for Medicare and Medicaid services within HHS and that person is Jonathan Blum. He's advised the Senate Finance Committee on various Medicare topics, he's served at the Office of Management and Budget, he's been a Senior Official at Avalere Health with responsibility for Medicaid and Long-Term Care and we're very glad to have you back, Jonathan.

JONATHAN BLUM: Great. Thank you, Ed. Thank you, Tricia, to talk today. I have four goals for this presentation. One is to give a very quick overview to how the Medicare program pays providers, health plans, Part D plans for benefits provided to Medicare beneficiaries. Second is to give

some thoughts from a CMS perspective of what are the current challenges facing the Medicare program. I think more important is to talk about the opportunities that were given to CMS through the Affordable Care Act to fundamentally transform how we pay for care, how we deliver care to Medicare beneficiaries, but then lastly to talk about some of the progress. I think in a nutshell we are seeing some very promising signs that care is being transformed, that payments are changing, and that to our analysis that the Medicare program is setting the example for how we want to pay for healthcare benefits for all coverage throughout the country.

In a real quick nutshell, Medicare beneficiaries have two general pathways to how they choose to receive Medicare benefits. Juliette talked about the traditional Fee-For-Service program where beneficiaries become eligible for Part A, choose to enroll in Part B, and also choose to enroll through a private drug plan, the outpatient drug benefit. The second pathway is that Medicare beneficiaries can choose to receive all three of these benefits, Part A benefits, Part B benefits, and also Part D benefits through a comprehensive health plan called the Medicare Advantage program. We have about a third of the beneficiaries in Part C of the private side of Medicare and about two-thirds right now in the traditional Fee-For-Service program, but the Part C as Juliette described, is

growing faster than the overall traditional Medicare program right now.

We pay providers, health plans, physicians, and just to breakdown how Medicare currently pays providers operating through the traditional Fee-For-Service program, the Part A side, the largest component is payments for inpatient hospital benefits through our DRG payments system. We also pay for skilled nursing facilities through the RUG payment system, pay for other post acute care providers known as long-term care hospitals (LTACs), inpatient rehab facilities (IRFs). The Part A program provides hospice care for beneficiaries that elect hospice benefits. The Part B side, the largest spending components are physician services that's bound by the SGR cap on total physician services, outpatient hospital benefits through a system called the APC payment categories, home health benefits, laboratory services, dialysis services, Part B drugs delivered through the physician office setting, and durable medical equipment that's now shifting to a competitive model from a traditional fee schedule model.

For beneficiaries that choose the Part D benefit they have to choose a private Part D plan. The Medicare program pays a fixed capitated payment per month to these Part D plans to cover Part D drugs covered by the plan that gets adjusted by

the beneficiary's income status or by their overall health status.

The Part C side, the private health plan side, we also pay plans a fixed monthly payment that gets adjusted for the overall health status to the beneficiaries. Beneficiaries who have a sicker health status the plan gets paid more to take care of that beneficiary. Beneficiaries who are healthier on average, the plan gets a smaller payment to insure that plans have strong incentives to care for both the healthy but also those with chronic conditions.

Shifting to the challenges to the Medicare program, there's really three fundamental challenges that I'd like to talk about. The first Juliette described well that the Medicare program is spending more over time. We'll talk about some of the current spending trends, but just one fundamental challenge to the program is the program is spending more as a share of GDP over time that policy makers have to respond to.

The second challenge that faces the Medicare program is that we see a tremendous variation in the spending that happens through our traditional Fee-For-Service program. You can map any payment category, any payment code and see a different pattern that happens across the country. This slide just shows that the spending variation for CT scans per traditional Fee-For-Service Medicare beneficiary and they can vary dramatically

across the country. There's different patterns that occur for different healthcare services and so one fundamental challenge that the program faces is to explain what drives these differences but whether or not they'll lead to different quality outcomes that I'll talk about in a second.

This slide compares a total hospital episode for a beneficiary with heart failure with shock complications and the Medicare program makes separate payments for the hospital, the physician, the post acute component, the readmission, and for the same beneficiary's health status we mapped out five areas of the country. You can see that spending varies dramatically for the same service, kind of same episode of care over a 30 day episode for the same health status beneficiary. It's not the inpatient costs that vary. Medicare pays fixed DRGs that vary very little across the country. This control is for teaching status, and dish status, but it's what happens to the patient after he or she leaves the hospital that drives the variation. Post acute care spending varies dramatically across the country, different readmission rates, so we are having a hard time trying to understand what's driving these differences, but this is really the secret I think to addressing the long-term financing quality challenges that the Medicare program faces.

This slide tries to illustrate that right now in our data we don't see much correlation between quality and cost outcomes. You can literally take a two-by-two matrix or a two-by-two chart and map quality metrics on the X-axis, cost metrics on the Y axis, plot different parts of the country. This slide just chose to look at hospital readmission, all cause readmission, a current measure for overall quality, total cost of care measures. Really, you can see that different parts of the country fall to different parts to the two-by-two matrix. There are high quality areas at low cost, high cost; low quality areas at high cost/low cost. We don't see much correlation right now in our data between quality measures and cost measures. This really goes to the notion that we have to think about different ways to pay for care to have all parts of our country provide high quality care at the lowest cost possible.

It is possible through our analysis to find parts of the country that do operate high quality/low cost. The challenge that we have I think is that we have to find ways to promote more of that behavior for all parts of the country. The good news is that the Affordable Care Act has given the Medicare program new policy tools to change how we pay for hospital services, physician services, health plan payments to our health plans. We are implementing and have implemented a

host of different policy interventions to fundamentally change how we pay for care within the Fee-For-Service program but also the Part C managed care side to the program. There are a couple themes to these payments.

One is to incent providers to become accountable for overall quality measures but also total cost of care measures. For example, we have the ACO program. We have now 250 ACOs (Accountable Care Organizations) operating in virtually all parts of the country. They're groups of physicians often working with hospitals to come into the program to be accountable for a large group of Medicare patients. It doesn't cause anybody to change their doctor or change their hospital. It's really a notion of becoming accountable for the total quality, total cost of care. If the ACO can achieve both the quality goals but also the cost goals they get to share in the savings.

The second theme to our payment changes is for just about every payment system that we make to hospitals, and skilled nursing facilities, and over time to physician services that that individual provider will receive a portion of their payment, small at first but growing over time, a differential based upon the overall quality of care provided to beneficiaries. For a long time now the agency has collected quality measures that encompass process care measures, outcome

measures growing over time, patient satisfaction measures, but over time just about all of our payment systems will be tied to the quality outcomes and increasing total cost of care outcomes for just about every payment channel that we operate.

We are now paying the health plans bonus plans based upon their overall quality star rating. For those plans who are rated four star/five star, five star is the best, one star is the lowest, they get differential payments now from the Medicare program authorized by the Affordable Care Act to incent plans to provide much more beneficiary centric care, higher quality care. Plans now have greater opportunities for higher reimbursement that will then also drive better benefits to their beneficiaries really to engage beneficiaries to choose the highest quality plans. We are seeing a tremendous shift in beneficiaries now choosing four star/five star plans while we are still making the notion what a four star/five star plan is much harder to attain. We are seeing tremendous shifts now in beneficiaries choosing four star/five star plans.

Last week CMS put out for participation a new bundled payment initiative to pay hospitals a combined payment for the hospital costs, physician costs, post acute care costs really to test different ways to pay providers. Getting back to that five city slide that I showed really trying to figure out what

it takes to have more consistent total cost of care of payments for a given episode of care.

Really, the Medicare program is transformed and I think compared to other private payers there's no other program, no other health insurance system that I know of that has been so shifted towards quality based payments, total cost of care payments. Really, I think from a kind of stepping back perspective that the Medicare program really is taking the lead to this notion to transform the delivery of care through new payment innovations.

We are starting to see tremendous signs of success. I can show various maps that show participation, the number of physicians signing up for voluntary ACOs, the proportion of beneficiaries that have shifted from low quality plans to high quality plans. The fact that we are now seeing a downward trend in overall hospital readmissions for the first time, so really exciting signs to show that the strategy seems to be working. What I think is most exciting is we are seeing I think for about the third year now historic lows in per capita cost growth. We're adding more beneficiaries to the program due to changes in demographics and CMS can't control the number of beneficiaries coming into the program. That's set by law, but we can control what we spend. We can set in place these new payment innovations that really change behavior and to

incent more providers to provide higher quality care, lower total cost of care and for the past three years now, we are seeing historic per capita lows in per capita cost growth. That really gives us very positive signs and very positive evidence that this overall strategy that was set by the Affordable Care Act is working. At first, the explanation was well, the economy is down so, therefore, healthcare costs are down. I think something else right now is going on within the Medicare program that we are seeing fundamentally different patterns of care, a recognition that we have to control hospital readmissions. We have to understand why we have this tremendous variation in quality and cost throughout the country. I believe that the strategy that has been put in place by the Affordable Care Act that is now being implemented is having a very strong response that we can see in our data and for the first time really say the strategy seems to be working.

Thank you for the opportunity. I'd be happy to answer any questions.

ED HOWARD: That's great. Thank you, Jon. Finally, we turn to Sheila Burke who is on the faculty at Harvard's Kennedy School among several other posts that she holds. A big chunk of her working life was right here in the Senate both as the Chief of Staff to Senator Bob Dole, his party's leader at

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the time in both the majority and the minority, and as the Chief Administrator Officer for this body. I think it's worth noting for today's discussion that Sheila has a degree in nursing and worked as a nurse early in her career, so she's been closely involved in healthcare issues for a very long time and we're very pleased to have you with us, Sheila.

SHEILA BURKE: Thank you very much. It would be frightening to put me back on a ward, so no fear there. Thank you very much, Ed, and thank you, Triche, for inviting me to be with you this morning. It is an interesting set of questions and what I'd like to do is to go a little bit deeper onto the challenges. Jonathan did a terrific job of touching on some of those and certainly Juliette gave us a terrific background in terms of the structure of the program but in fact, not withstanding Ed's desire not to talk politics, the reality is that Medicare is very much caught up in the discussions of the day. It has in fact been tremendously successful in providing coverage to the elderly in this country and the disabled, certainly, the 50 million people in 2012 that were covered by the program. It has achieved a great many terrific outcomes, some of which were reflected in the terrific film that Kaiser has done.

The fact is that the expenditures are expected to rise as a share of the federal budget and the nation's economy and

it has put the program once again in the forefront of discussions with respect to the deficit and with respect to spending. This is not, I should underscore, a new story. We have faced issues of cost growth in the program almost since its inception in 1965. We have worried about the variations that Jonathan pointed out on his slides in terms of the differences around the country in terms of the costs of services, the utilization of services. We have worried for many years about the quality of the care that was actually being received and whether in fact it was at the level that we expected it to be. The chart here shows clearly while slowing, there is nonetheless a continuing increase. While the trust fund is financed through payroll taxes, that is for Part A of the program as was pointed out. Part B of course is in large part funded by general revenues that match essentially the amount that is paid in premiums so that the increase in the program costs are not simply a function of what occurs to the trust fund but also an impact on the rest of the budget and has been pointed out by many a declining resource available for other expenditures that are as important to us as Medicare in terms of the program. Things like FDA, CDC, NIH, a whole variety of programs that are funded that are discretionary in nature of course are put at risk when in fact we use an

increasing percentage of the federal budget for the program expenditures.

Partly as a result of the payment changes that Jonathan pointed out that were incorporated in the ACA and the general slowdown in the use of services, which we believe in part was a result of the recession and the fact that people didn't seek them as frequently, Medicare per capita spending is now projected to grow at 3.9-percent annually from 2012 through 2021. As I will show you in a moment, the growth in the enrollment will continue to place great pressure on the program. Again, of course there are continuing questions with respect to quality as Jonathan pointed out and the question as to whether in fact we are getting the services that we want to get for the most reliant in our country on this program. We know that aging in fact will put a great burden on the program.

This terrific slide, and this is in your packets and I would point out that Kaiser in cooperation the AMA has been doing a series of info pieces for JAMA that are really quite terrific and really do a terrific job of sort of describing the very complicated program in very straightforward ways. I encourage you to utilize in talking with some of your own constituents. Again, the program's rate of growth is slower than we see on the private side, an important note, and I think the result of a great deal of effort over the last few years in

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terms of restructuring the program. In fact, while it is at an all-time low in terms in per capita expenditures, the population which is expected to reach 81 million by 2030 is going to continue to put enormous pressure on the program as we go forward even if the per capita spending continues to remain relatively low.

Here is a terrific depiction of the challenges that we face under the overhang of the deficit. We want to make sure that our payments are fair so access to beneficiaries is secured. Some of the payment changes that have been described by both Juliette and Jonathan are an attempt to try and restructure and rethink how we finance services, how we encourage better use of services, and how we encourage more efficient delivery of services. Again, we want to make sure that however it is that we decide to pay whether it is for physician services, hospital services, outpatient drugs, or any of the other things that Medicare currently pays for are in fact sufficient to encourage those to participate the program and access is assured for beneficiaries. Cost sharing and premiums have consumed a larger and larger share of the annual social security benefits that the elderly receive over time up to almost 26-percent on average in 2010. While recent changes have focused on higher income elderly, some of the changes that were incorporated are the ACA and other changes that

essentially targeting higher income beneficiaries. As Juliette correctly points out, the majority of the Medicare beneficiaries are in fact not all playing golf living in Palm Beach. They are in fact a relatively low income population dependent upon social security as their primary source of income.

How we utilize cost sharing, how we target cost sharing to encourage appropriate utilization of services while maintaining access and not encouraging people to delay care is quite important. It is an issue that we have focused on for many years and that is what is the right and appropriate use of cost sharing and what is the right and appropriate amount of cost sharing. This issue has come into play, obviously, the changes with respect to preventive services to encourage their utilization. Questions have arisen with respect to the share of the deductible and the co-insurance on physician services, on hospital services, and others. Again, we want to make sure that the burden is an appropriate one and is not excessive nor leading to delays in treatment but in fact encourages appropriate use of care.

Finally we worry about the long-term sustainability of the program and its impact on the budget, which is the reason that it is in fact much in mind today as we think about the deficit issues. One of the particular challenges of course is

that healthcare coverage, while important to people of all ages, it is particularly important for the elderly and the disabled as we see evidenced in the utilization of services by that population. Every year three-quarters of those who are on Medicare, who depend on the Medicare program, have at least one physician visit and one in five visit a hospital. Juliette showed a sum of those numbers in terms of utilization. In 2013, the average per capita Medicare beneficiary will exceed expenditures $12,000.00. While most use Medicare services infrequently, the majority of the spending is on a relatively small number of beneficiaries as evidenced here.

One of the challenges that we face in looking at the program is essentially how to focus on that population. How to essentially look at those who are in the greatest use of services and the most costly services. Some of the discussion around the ACA around the dual eligible's, that is those who are eligible for both Medicare and Medicaid, there are about 9 million of them, tend to have a very high use of services. One of the questions is are we doing the best job we can to coordinate between Medicare and Medicaid for this population? Are we in fact encouraging appropriate use of services and coordination between those two programs? Again, it is a focus of the element of the ACA how best to target these individuals

and how best to address those particular concerns and those particular costs.

As is evidenced here, we continue to worry about the Part A trust fund. The aging of "boomers" like me not only increases those eligible for the program, it also reduces the number of workers who are paying into the program, a primary source of revenue for the HI trust fund. The 2012 Trustee's Report suggests to us that the program is currently scheduled to remain solvent until 2024, but will then have insufficient funds to pay bills. The reality of the trust fund is no money, no bills so that this becomes a very serious issue and the options to essentially address these issues include a restrain in spending as well as additional revenues.

Finally, before we open it up for discussion there are a host of strategies both long-term and short-term and we have begun to hear them discussed in the context of the current budget discussions. Kaiser has put out a terrific compendium of possible proposals. CBO has done this routinely, others have done it as well, but they tend to fall in these categories. This is not by any means an exhaustive list, but really an illustrative list of the kinds of things that are likely to be considered. With respect to providers, payment reductions, the easiest thing to do is just cut across the board or in some portion of the program. In fact, great

attention is being spent on how to really restructure the way we finance services.

Medicare is an outdated benefit design. It is confusing to beneficiaries and providers. There are relatively high cost sharing and deductibles, no limits on out of pocket costs and large gaps in coverage — long-term care comes to mind. The payment system is inherently inflationary with the basic method fee for service where you pay more and you do more so all of the initiatives that Jonathan suggested are being considered are really to rethink how you structure that payment system to essentially get coordination of care and essentially, efficiency in the delivery.

Issues around the beneficiaries. The program was created in '65. The date that was chosen in terms of eligibility was at that time 65. Questions have arisen as to whether that is still appropriate in today's world with the lengthened mortality and essentially the people staying in the workforce.

The role of cost sharing. Again, cautionary notes about whether it distracts or disturbs access or limits access to coverage, but, again, the question is to whether we ought to rethink the way we in fact incentivize behavior on the part of beneficiaries to utilize services.

How we pay the plans, Medicare Advantage plans. There are changes in the Affordable Care Act, further questions going forward about how to incentivize quality. Then the basic structure of the program. We've heard the program redesign premium support is one of the options that some have suggested. Restructuring the benefits so it doesn't have that old Blue Cross Blue Shield model of A and B being separated and create a more coordinated benefit so that in fact people are managed across the full continuum of care. These are among the things that are being considered, but in fact, the time will come again as it has that we will look at Medicare in the context of the budget but hopefully with provisions that make sense going forward.

ED HOWARD: Great. Thank you very much, Sheila. Could I just ask a clarifying question? I thought I heard you say at one point on the slide describing the distribution of Medicare beneficiaries and spending that the average cost was 12,000 or 9,000?

SHEILA BURKE: It is 9,000. It's projected to go to 12,000 on average per beneficiary.

ED HOWARD: Very good. Thank you. We have lots of questions that we can ask but we want to make sure that we cover the questions that you want to get asked. As I said before, there are microphones that you can use to ask your

question vocally, in which case we'd ask you to keep it fairly concise and identify yourself. Then if you have a question you want to write down on one of those green cards someone from the Alliance staff will snatch it from you and bring it forward. Tricia, do you want to start us off with a question or two or I can as well. Go ahead.

TRICIA NEUMAN: Jon, this is a question for you. There was a lot of concern during the debate around the Affordable Care Act about Medicare Advantage and whether enrollment would decline a lot. We've seen enrollment rise a lot, more people gravitating toward Medicare Advantage plans. What are you starting to think about the future in terms of enrollment?

JONATHAN BLUM: I mean I think overall we have seen a much different response than some had predicted when the Affordable Care Act passed. The notion was plans would pull out, beneficiaries would go without the added services that these plans provide and the opposite has happened. We are paying less on average to health plans than we paid before the Affordable Care Act and we are seeing the same degree of access of plans and beneficiaries choosing plans at a faster rate than the traditional Fee-For-Service program. In 2011, CMS predicted that we would have about 10-percent growth in 2012 and we were pretty much spot-on with that prediction. We are predicting 10-percent growth in 2013. We are seeing very

positive signs so far that that prediction will prove true so I think we're coming into a time that is much different than the past. In the past, back in the 90s when Congress reduced payment rates, the plans pulled out and that caused a tremendous disruption for beneficiaries. I think it's a different time, a different experience, and we have brought plan payments down dramatically. We're still on track to bring them down further per the Affordable Care Act, but we are seeing no signs of decreased access. Average premiums have fallen, not risen. Cost sharing has fallen, not risen. Benefit levels have stayed the same, not diminished and beneficiaries are signing up for the program at a much faster rate than the overall growth in the program. We are very optimistic of the program's future and that's one of the reasons why we felt that it was so important to incent payments for four star/five star plans. Because if we want to accomplish all of the payment reforms, delivery reforms, we have to make sure that we're focused not just on the traditional Fee-For-Service program, but the part of the program that's growing the fastest. That's why it was so important to us to have the five star bonus payment system to incent more plans to achieve higher quality levels given where beneficiaries now are choosing to receive their services.

ED HOWARD: Yes, go right ahead.

AMY: Thank you. Amy Zeitel Research Group. Thanks so much for holding the panel. It's been really helpful. This question's for Mr. Blum again. I have a couple questions actually, so take them as you wish. For Part D I'm wondering if plans will be subject to the minimum loss ratio in this upcoming year and then to the MA topic I know preliminary rates will be released shortly and I am wondering if you can go into more detail about how the ACA rebasing or cuts will impact the projected rates for the coming year. Then lastly, if you wouldn't mind touching on competitive bidding for DME. I'm wondering when the recomplete bids will be released.

JONATHAN BLUM: I think you're asking me questions that I can't answer yet. We are on track to release the proposed payment rates for the health plan for 2014 and so that will come out in the next couple days. We will have more to say when the proposed rate structure is public. Plans will have the opportunity to comment and the same is true for durable medical equipment round one recomplete. What I can say as generally is that both in the context of competitive bidding for durable medical equipment we moved to a new pricing structure that's being phased in across the country. We were just seeing phenomenal results with the program. The same is true with the payment changes that were authorized with the Affordable Care Act to our health plans and a much different

response than I think some had predicted. I think really both of these programs, the changes to the MA program, the changes to how we're paying durable equipment, to us there is tremendous signs that we can reduce payments without compromising access to quality of care providing much greater value to our beneficiaries. I will have more to say in a time when it's appropriate.

ED HOWARD: Can I just ask you to explain to some of the new people in the room or some of us who might have forgotten it what the medical loss ratio really is?

JONATHAN BLUM: Sure. In broad terms, medical loss ratio has to do with the portion of the premium paid by beneficiaries and in the case for the Medicare Part C program, the share paid by the government that a sizable portion (85-percent or more of the total premium) has to be paid back to beneficiaries in benefits. The Affordable Care Act authorized this new requirement for Part C plans starting in 2014 so CMS will have some proposals soon to put in place that — those policies.

TRICIA NEUMAN: This one is for Sheila, but it could be for anybody. Can you explain to us why or how Medicare will run out of funds by 2024 if people continue to pay their Medicare payroll taxes as they are supposed to? Would an

increase in the Medicare payroll tax prevent it from going bankrupt?

SHEILA BURKE: Well it's an interesting question. I suspect we'll be tested. In part, the issue is the decline in the number of people that are contributing. As the "baby boomers" essentially retire the number of workers to retirees declines and as a result, the income to the trust fund declines over time as the number of people drawing on the trust fund become larger in number. Certainly the question of an increase in the payroll tax is one that is often considered in the context of the program. It might well continue to be. There are questions as to the nature of the payroll tax and its impact on the population and whether you target it on largely higher income individuals or whether you spread it across the entire payroll base. Again, it is certainly a source of revenue. It would certainly make a difference in Part A but the draw on the trust fund is in part because of the number of retirees to the number of workers.

SHEILA BURKE: Here's one for Juliette. What would you say are the costs and benefits or the pros and cons of raising the age of eligibility to 67? Of course, anybody else who has thoughts on that chime in.

JULIETTE CUBANSKI, PHD: You can watch the Alliance/Kaiser sponsored briefing from December last year on

raising the age of eligibility if you want lots of details. Basically, one of the main concerns with raising Medicare's eligibility age prior to the passage of the Affordable Care Act was that you would create a large population of people who would have no access to health insurance. Many people when they turn 65 rely on Medicare for their health insurance coverage because they no longer have access to employer sponsored coverage and private insurance is an often prohibitively expensive option. With the passage of the Affordable Care Act this created new channels for insurance coverage for non-elderly people. Through the state based exchanges it's likely that if Medicare's eligibility age were raised to 67 our analysis showed many people would have access to coverage through these exchanges or marketplaces I guess as they're now called as well as expanded Medicaid coverage.

A big concern however, is that the cost to many people would also be higher than if they were to remain on Medicare. There would also be higher costs to employers, higher costs to states, and the net effect of raising Medicare's eligibility age is actually higher total cost overall. On the plus side, Medicare saves some money, the federal government saves some money, but there are additional costs to the federal government associated with the subsidies for exchange coverage and the

Medicaid expansion so it's not exactly a win-win according to the analysis that the Kaiser Family Foundation has conducted.

ED HOWARD: And I do endorse Juliette's referring you to the briefing that we did in December. There are a lot of good materials and a webcast you can watch. We have several related questions and, Jon, maybe you can take the first crack at it because it has to do with Medicare Advantage plans. The most general asks how the star rating system that you referred to works and that is related to a question that was not asked here but was asked by a Senate office to us which is how come a lot of money didn't go to four and five star plans but went to three star plans this time around? Relate that if you would to this question. I'm sorry to overwhelm you, but they are related. Explain how the ACA cuts to Medicare Advantage plans are scheduled to take effect. I understand that only about 4-percent may have taken effect now and do you anticipate that some of the access problems you referred to and perhaps lesser benefits are going to show up later in this phasing in?

JONATHAN BLUM: I'll take them out of order, but I will try my best to answer all three questions. Before the Affordable Care Act, on average the program paid health plans about 14-percent more on average than the cost for the same beneficiaries in the traditional Fee-For-Service program. There was an overpayment on average of about 14-percent

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compared to the cost for the same beneficiaries provided services to the traditional Fee-For-Service program. That so-called overpayment's being phased down by the Affordable Care Act and today we're paying close to 7-percent more on average, about half of that so-called overpayment, phasing down very close to 100-percent on average.

The main way that the Affordable Care Act changed the payment structure to plans is to bring the overall average payment, there's still going to be difference across the country, but very close to the average cost for the traditional Fee-For-Service program. Prior to the law being passed 14-percent overpayment, 7-percent today on track to phase down to 100-percent. The law also authorized bonus payments for those plans that produce higher quality star ratings than the average plan. CMS for a long period of time, since 2007, has collected roughly 50 to 60 various measures that go through consensus processes. They have to do with everything from plan performance to moving towards quality of care outcomes. We have collected all these measures and then transferred those measures to an overall score to a plan: one star, two star, three star, four star, five star with four star and five star being what we really want the goals of the program to achieve.

Through demonstration authority, CMS kind of built upon this program to create a more gradual scale starting at three

star going up to five star really to incent quality improvement and there have been some criticisms regarding this demonstration authority. The data that we see today and the data in overall improvement gives us great confidence this program is working. We have seen while making the measures much harder to be a four star/five star plan it went from now about 16-percent prior to the Affordable Care Act beneficiaries being in four star plans, none being in five star plans now to more than a third, 37-percent of beneficiaries now are in four star/five star plans.

When I talk to health plan executives about why are they making this transformation they really say it's the incentive structure that was created really to incent quality improvement from three to three-and-a-half, three-and-a-half to four, four to five and that's really the goals of the program. We are seeing a fundamental shift in how the market now is being created from a program where plans were paid 14-percent on average overpayments relative to traditional Fee-For-Service now coming down, strong incentives to improve. To me this is a sign that we can reduce payments on average, we can create high standards and see beneficiaries respond with 10-percent growth last year, projected and on track 10-percent growth to 2013. Comparisons to the past to me aren't very helpful to explain how the program's working today.

ED HOWARD: At the risk of beating a dead horse, while you were responding I got another question on a card that's related and might be helpful to people. Can you talk a little bit about how you decide what the criteria are for the star ratings?

JONATHAN BLUM: I think two fundamental things happen. First is that we work with the NCQA. That's an independent association to set the measures, collect the data. Most of our measures are kind of established, collected through independent third-party sources then our staff converts that measure to a standard for what it is to be a four star/five star plan. We have to set some standards to what we think is high performance to achieve four star/five star status. We are making some judgment calls and our judgment is we have very high standards for what it means to be a four star/five star plan. We believe that any plan can achieve four star/five star status and, in fact, we have shifted the criteria to emphasis less about the process measures like how fast the plan answers the phone for customer service to the outcome measures and the beneficiaries' satisfaction measures. In the last couple of years we have shifted the standard more to emphasize quality of care measure and beneficiary satisfaction measures but we are making judgments to what it means to be a four star/five star plan and our judgment is the criteria is high. Most plans don't achieve

it, but we are trying to create the incentive structure to achieve it. I believe with this model now we are seeing a fundamentally different market that beneficiaries and plans are responding to.

TRICIA NEUMAN: Sheila, or maybe Juliette, could you speak more to the consolidation of Medicare Part A and B and having — this is written for Sheila — and having one singular co-insurance as has been floated in Simpson-Bowles and more recently by Senator Hatch and Representative Cantor?

SHEILA BURKE: This goes back to the fundamental question of the structure of the program, which was originally based on a Blue Cross Blue Shield model where essentially the physician services were separate from the institutional services. The question that has arisen is whether or not that model in fact remains current today or whether we ought to create a model where there is a single deductible and co-insurance to encourage more coordination across the full array of services that are provided to a Medicare beneficiary.

Some of the initial cost estimates suggest that there will be a higher cost to a number of Medicare beneficiaries because of the current utilization of services where there's a greater frequency of utilization of physician services as compared to hospital services. One of the questions that Simpson-Bowles raises and that we are trying to understand is

what the impact of that change might be. It is really an attempt to try and create a more coordinated, consolidated service so that essentially the benefit is structured in a way where there are more incentives to coordinate among the different sites of services. Again, the question will be what the impact would be on beneficiaries and whether in fact it would result in a higher cost sharing for a larger number of individuals.

ED HOWARD: Go ahead.

TRICIA NEUMAN: It's great cause we do have a lot of questions and they're all really good questions. Is competitive bidding something that should be considered for other areas like hospitals, doctors, labs, and other things that Medicare pays for? Then it says is the drive to increase bundling where episode cost and quality is the focus a type of competitive bidding?

FEMALE SPEAKER: No.

JONATHAN BLUM: That's for me?

TRICIA NEUMAN: I think so.

ED HOWARD: You can start.

JONATHAN BLUM: We have seen tremendous success right now with our competitive bidding program for durable medical supplies like power wheelchairs, and diabetes test strips, and kind of routine supplies that beneficiaries purchase or rent.

We have seen phenomenal savings from this program that both benefit taxpayers and also beneficiaries, but also this new program hasn't compromised quality of care. In fact, we think in some respects that it has raised the bar for quality of care. I think it is an open question whether or not other services, other spending categories can be brought into more competitive bidding models. We have flavors of this already that show us signs that competition helps to lower overall costs.

Part D plans for example are paid on a pure competitive bidding model and Part D have grown much lower than predicted when the Part D benefit was authorized back in 2003. There are positive signs that this model can produce greater savings and greater access and quality to beneficiaries.

The bundled payment models that we announced last week all have an element that hospitals participating offer savings to the program. They say this is a savings target that we can meet. We are starting to use competitive principles more and more through demonstration authorities and other means to test different ways to pay providers but you really have to think about different competitive models depending on the payment category, the mix of providers. So far, we have seen very promising signs that competitive bidding models can produce

greater value and potentially greater quality of care to our beneficiaries.

SHEILA BURKE: Tricia, could I just comment? I want to talk specifically about the bundling issue which I don't really think of in the context of competitive bidding. This was true of the work certainly that the department's doing but work that the bipartisan policy center is doing and others. That is the purpose really to look at bundling is to try and reduce the kind of silo-based payment system that we have today that really requires little in the way of coordination across the sites of care, across a continuum of care. In particular, at least some of us are quite concerned about the handoff that occurs in a post acute environment where essentially there is no particular incentive for the acute care to really track what occurs when someone's post acute. There has been recent attention to readmission strategies and whether or not we're seeing too many readmissions and really kind of a disincentive to do so.

It is really the much broader question which is how do you encourage the full array of providers that take care of a particular patient to begin to coordinate much more closely in terms of the utilization of services. Bundling is really I think some of us think an attempt to try and look at those incentives. To try and do a better job of helping patients

manage throughout that full array of services so that from a pre-admit to an acute care episode to a post acute management over time that there's more attention given to those handoffs and more coordination in terms of the sharing of information so that essentially the patient isn't having to sort of reestablish the data set every time they see a different provider. Whether they go from an acute care hospital to an LTAC, or to a home health service, or to an intermediate care facility, we really want to try and look at the full array of services and create an incentive for someone to take ownership of that arrangement and ownership of that management of that particular patient in that particular condition.

ED HOWARD: Sheila or Jon, we've got a follow-up question here that looks at the initiative that was announced last week. There were several models that the administration proposed and the questioner is wondering whether you're worried that putting particular bundles together is going to sort of freeze this experiment and hinder innovation in the way you put the bundles together the way some private sector providers are doing.

JONATHAN BLUM: I think we put forward four different models for bundled payments really starting with a hospital episode of care, a DRG. We tried to find the balance between standardization versus flexibility given that we really wanted

to incent providers to come in with the proposals about how to think about different ways to pay care. At the same time, we have to be able to assess what works, what didn't work. Going back to the slide that I showed with the five different cities with the same DRG there's tremendous variation in the total cost of care primarily around hospital readmissions and as Sheila said, post acute care. We are really trying to figure out what is the best way for hospitals to work with post acute care providers to reduce readmissions, to make sure that there's a much more balanced distribution of spending in the post acute care spending channels that we have. We set sort of a set number of DRGs. Here are the ones the hospitals can choose to participate in. Hospitals have the opportunity or health care providers participating can choose which DRGs they want to take, but we have different models. Some models just combine the physician with the hospital. Some models combine the physician, hospital, post acute. Some just focus on the post acute.

We're really trying to figure out what works, what doesn't work and one hypothesis is different models will work differently in different parts of the country given how dramatically different the healthcare provider mix is, the difference across the country, the cost, the quality structure. We tried to balance attention between fostering creativity but

also having some standardization so we can assess what works, what doesn't that we can build broader policy on.

SHEILA BURKE: To Jonathan's point I think one of the areas of complexity is the data that needs to be understood and gathered across those sites of care so that the information in fact can be given to all. I spent a fair amount of time in my career in the Senate worrying about rural areas, particularly in the Midwest. Osawatomie, Kansas comes to mind. If you think about the discharge patterns from regional centers to essentially long-term care facilities that may be quite a distance and they aren't necessarily in vertically integrated institution, but rather someone's essentially come into Kansas City and going to get shifted back to the big first. Just understanding where people go, understanding how you might coordinate those services is not a simple process. I think one of the issues the department is appropriately trying to understand is where do those bundles make sense and with whom and how. I think rural areas in particular need particular attention in these areas, but it's true of urban areas as well where people may be discharged to any number of different locations which may or may not have a relationship with the institution where someone was cared for

It is, again, I think to the benefit of the beneficiary for us to understand those patterns and to try and help manage

that but it's not a simple process and I think the department's really struggling to understand what do we know, how much data do we have, how many providers are involved. If you think of the number of specialists that any elderly person sees I mean there could be any number people. I think it's a direction that I think a lot of us would like to see things move.

ED HOWARD: Got one? I got one.

TRICIA NEUMAN: Sure, here's a question. General revenues seem to be a significant source of revenue for Part B and Part D. Was that done on purpose? Was that by design? Why did that happen?

SHEILA BURKE: Well Juliette is the historian in the group but I will comment just briefly. The program when it began in 1965 was in fact a process of accommodation for the individuals that were involved. There was great importance placed on the separation of B from A and the voluntary nature of Part B, which were physician services. It was accommodation for the AMA that was very much opposed to the creation of the program at the time and the desire to make sure that essentially no one was compelled to participate in a federal program and that the relationship between the beneficiary and the physician would remain a voluntary relationship. The introduction of premiums and the introduction of general revenues, which at the time were designed to be 50/50, but then

essentially in years where the premium exceeded the rate of increase in the social security paycheck. You would essentially have had a reduction on your social security check to pay your premium, there was an effort by Congress to essentially put a limit on what the size of that premium would be to essentially 25-percent. We've increased that very slowly over time. At the heart of it was this desire to make it a voluntary program. Similarly, the same principles were applied in the creation of Part D and that is to have a voluntary choice on the part of the beneficiary to belong and a voluntary choice to participate and that premiums would play a role in the financing of the program and not be trust fund or payroll tax financed.

JULIETTE CUBANSKI, PHD: I would add to that that we talk about the Part A trust fund solvency. The fact that Part B and Part D are financed with a combination of general revenues and premiums means we don't talk about the solvency of the Part B and Part D trust funds. The funding for Part B and Part D is set annually so that premiums go up, the general revenue contributions go up every year to match whatever the projected expenditures are for the coming year for those programs.

For Part A the issue of course as a questioner mentioned earlier and Sheila addressed, it's payroll taxes.

Whatever payroll tax is coming in that's whatever money is available to pay for benefits that are being provided. The concern with the solvency of the Part A trust fund come in 2024 and later years is that the income won't be sufficient to match the expenditures going out. The Part A trust fund doesn't go bankrupt in the classic sense that there's no more money left to pay for benefits, it's just that the funds coming into Part A isn't sufficient to fully pay for the Part A benefits that will be delivered that year.

ED HOWARD: Thank you, all. A question came in, in advance of the program wants to know how widespread of an issue is Medicare fraud and we might add and what is there more to be done beyond what's being done now?

TRICIA NEUMAN: And maybe to add on top of that who in the government is doing what about Medicare fraud because we always hear about fraud busting?

JONATHAN BLUM: I think going back to the slide that I showed about the map with the geographic variation, we see tremendous variation for all different services. If we really drill into that variation sometimes it's driven by a handful of providers in one part of the country who are driving utilization that far exceeds the average. I think generally there's no one pattern, there's no one cause, reason to fraud in the program. We know it exists and there's tremendous

resources and programs that are being implemented to try and address it. There are three really kind of key agencies right now that focus on Medicare fraud. There is CMS whose real job is to set payment policy and to set programs to stop fraud before it happens. We are investing a lot in data resources, data analysis really to find patterns of spending so we can address spending patterns that appear to be fraudulent through payment policy edits, more investigations. The other key agency is the Health and Human Services Inspector General's Office that has tremendous resources, agents to investigate fraud providers and then to help take action to stop behavior that is fraudulent. We also work very closely with the Department of Justice that is really the prosecutorial arm to investigating fraud.

Really it is kind of three part entity. CMS's primary role is to stop fraud before it happens. The IG, DOJ really to investigate and pursue those that are committing fraud. There's no one measure that gives an overall sense to fraud. We're working to develop that measure, but we know that it is spread in many parts of the country. It tends to kind of move around as more resources are applied. We have put in place a whole new framework, largely again the Affordable Care Act, to assess, stop, monitor and to respond to known fraud spots of the country.

ED HOWARD: I've got a cost question. It refers back to some of the slides that were displayed showing projections in the future. How much of that cost increase is due to the demographics that have 10,000 "boomers" turning 65 every day and how much is due to the projection in increases in healthcare costs underlying the entire healthcare system?

JULIETTE CUBANSKI, PHD: The last projections that I saw suggested that the age increase in the number of elderly accounted for about 60-percent and the increase in cost accounted for about 40-percent.

JONATHAN BLUM: But I think in the last couple of years that per capita costs have been virtually flat. The cost growth right now is driven by more Medicare beneficiaries coming into the program. I think that's what's driving the cost today. I think in the future Sheila is right that the majority of cost driven by demographics but in the last couple of years virtually all the cost growth is driven by demographics.

JULIETTE CUBANSKI, PHD: I think the Congressional Budget Office's most recent report said that Medicare spending growth is growing at the lowest rate than at any time since year 2000, which is pretty astonishing.

TRICIA NEUMAN: I have a question which is sometimes I hear that people on Medicare have a hard time finding a doctor

who will see them. Is that true? Are there national survey's to say that's true? What's the evidence.

JONATHAN BLUM: We track very carefully physician participation data and beneficiary access data. I think overall the trend is very positive that most physicians choose to participate within the Medicare program, that it's voluntary for a physician to choose to participate, but I think somewhere in the neighborhood of 94-percent of all physicians choose to participate within the Medicare program. I think on average beneficiaries report good access to finding physicians. I think we have some parts of the country with some data that shows us signs of concern, particularly for primary care physicians, but overall that it's just in isolated parts of the country, but overall very strong physician participation in the program and overall on average beneficiaries report being able to find physicians quickly when they need services.

TRICIA NEUMAN: Anybody else?

ED HOWARD: Jon, has the department looked at what might happen when some portion of 30 million new beneficiaries qualify for coverage under the Affordable Care Act over the next few years in terms of its impact on Medicare beneficiaries being able to see a primary care provider?

JONATHAN BLUM: I think there has been lots of work to be done that's going on right now to build a workforce to

respond both to the demographic changes in the Medicare program but also to the fact that millions of more beneficiaries will be covered by the new health insurance programs. I think we are conscious of and have to be mindful that we have a workforce that's sufficient. A lot of the payment innovations that are being put into place really emphasize primary care as being the center part of the ACO model. We have new primary care bundled payment models going into effect so this is really an effort to build a much stronger work force, primary care workforce to respond to the greater need. We have other parts of the department focusing on ways to promote more nurse practitioners, other health care professionals to take a more central role in the delivery of healthcare. Some of those are also being tested through our center for innovation. Many of our payment activities also go to help support a stronger workforce both to support the Medicare demographic changes but also the larger changes going on to expand coverage to all Americans.

SHEILA BURKE:ED, if I could just add one additional comment to build on Jonathan's point, one of the fundamental questions for Medicare historically, but for us now generally is this question of workforce and the utilization of non-physician providers in particular. There are initiatives in the ACA and other work going on that Mary Wakefield and others

are looking at in terms of how if one encourages the creation of teams, the role that nurse practitioners, physician's assistants, community care workers essentially can play. Medicare's reimbursement rules in the past have discouraged the utilization of those providers in many instances except in unique circumstances. Nurse anesthetist comes to mind, role clinics, and things of that nature. This whole question of scope of practice, which is essentially more a state issue than it is a federal issue, and that is the extent to which states permit people to practice to the full extent of their license is one of the questions that's being raised. As we look at these new payment systems, how essentially we rethink the creation of teams and the role of non-physician providers on those teams.

ED HOWARD: Very good point. A very factual question and it has to do with actually Juliette's laying out where get people get benefits and when and the questioner wants to know whether one can receive Medicare even if they delay receiving social security benefits.

SHEILA BURKE: (Interposing). Yes, they can. Yes is the quick answer to the question.

ED HOWARD: Yes.

SHEILA BURKE: It's more elaboration.

JULIETTE CUBANSKI, PHD: It is a little bit more complicated now because with people delaying social security retirement it probably makes sense to tell people to go to their social security office if they want to be sure they get on Medicare because the two programs are not perfectly aligned at 65 as they used to be. So to avoid a glitch in Medicare coverage it would be a great idea for people who are approaching 65 to head down to their social security office to be sure if they are still working that they can get Medicare.

ED HOWARD: Good. We have some other questions that came in but they're a little bit off the track that if we're going to try to cover the basics we don't want to burden everybody with crawling through the weeds. Wait, I was about to give you a reprieve but this gentleman is taking away your extra time.

KEVIN GRONER: I'm going to just ask you —

ED HOWARD: You want to identify yourself?

KEVIN GRONER: Kevin Groner with Advanced Patient Advocacy. A real basic question cause we've heard and heard talks about what if we increase the age to 67 and we talk about a lot of ways to reduce costs. If I can put it in a real basic way, if one's life started on January 1st and it ended on December 31st, if by the month of December that individual is really receiving Medicare benefits, how much do we actual pay

if the average over that course of that lifetime was $10,000.00 a year, how much is spent on New Year's Eve? In other words, one's healthcare marathon typically is most expensive in that last mile. How much are we spending on those beneficiaries in that very end of life question and are we ready to talk about that? Thanks.

JULIETTE CUBANSKI, PHD: Study I saw said 25-percent of Medicare spending is for people in the last year of life. Are we ready to talk about this? I think a lot of people in the healthcare delivery system do talk about it. I think people in the medical world do talk about it. I think in the policy world it gets very difficult to talk about it because these are very personal decisions between families and their physicians and their healthcare providers. I think we saw what happened when Congress tried to do something fairly simple in the ACA with respect to these discussions with doctors. Yes, it's an important issue, yes, it's a big statistic, yes, it accounts for a large share of spending but how to deal with it is a tricky question and it sometimes is talked about in the policy world but maybe more comfortably in a world with families and their doctors.

ED HOWARD: Tricia mentioned that this was a primer that we traditionally do at this time of a new Congress. I want to emphasize that it's the first of a number of them that

we're going to do in cooperation with the Kaiser Family Foundation. We have scheduled a Medicaid primer, an ABCs session for March 1st and we will roll out subsequent primers on the Affordable Care Act and on healthcare costs in general. You've heard pieces of that surface in this conversation as well. We want to thank the foundation, Drew Altman and Diane Rowland and their colleagues and the folks from the foundation present at our panel for their active involvement in all of this work.

One last plea for you to listen to this gentleman's question.

MALE SPEAKER: I've heard recently that among developed nations the U.S. has fallen to the bottom as far as longevity is concerned and yet we're paying a lot more than other people. Wouldn't it save substantially on Medicare costs if we veered away from "the pill for every ill" mindset that we've kind of adopted in the country and look at other measures such as prevention alternatives and educating people on things like genetically modified foods and the long-term dangers they could present?

FEMALE SPEAKER: I don't know who wants to take this. Questions often come up about improving coverage of prevention sort of over the course of a lifetime and in Medicare. There's been a lot of interest in that and there have been a lot of

improvements lately. One of the sort of unfortunate realities of living in this town and working where the Congressional Budget Office is a scorekeeper is sometimes those initiatives, though people believe they will save money, the Congressional Budget Office actually scores an increase in spending depending on what the preventive service is. They don't really have a lifetime view or they may not have the evidence to say that it does save money. That said, there have been improvements and it sounds like Jon wants to add.

JONATHAN BLUM: I think we are right now in the Medicare program transforming how we're paying for care. We are changing the incentive structure to be from only about paying for the service when the beneficiary needs that service to taking a more holistic approach, looking at the total quality of care measure over a span of a year for example. Looking at the total cost of care over a 30 day or a 90 day period, which provides much stronger incentives for care providers to focus on prevention, focus on wellness, focus on primary care. We believe with these payment changes and new incentive structures that we're going to see the shift that you're talking about towards prevention, towards wellness. We still want the Medicare program to provide every service that a beneficiary needs when he or she needs it, but at the same time we want to make sure that the healthcare system is kind of

oriented towards focusing on prevention, wellness, and keeping beneficiaries as healthy as long as possible. It's in the best interest of beneficiaries but also in the best interest of the program.

ED HOWARD: Whether or not it saves large amounts of money in the short run or the long run. There's a CBO exercise that we described in a briefing last year in which they modeled a theoretical 50 cent increase in the federal cigarette tax, tobacco tax. In making those calculations out to 50 years they did a fair amount of sophisticated assumptions about things like drawing social security benefits for a longer period of time and therefore, costing the government more money. The panelist from CBO pointed out that in the end, regardless of prevention of a particular condition the mortality rate remains 1.0 so you may be just keeping people alive long enough to get another thing that you're going to have to pay to try to treat. We are looking forward to the sophisticated cost analysis but not necessarily as a full justification for rolling out better prevention benefits for people in Medicare and otherwise. I didn't mean to sound off there but there I go.

FEMALE SPEAKER: There you go.

ED HOWARD: "There he goes again" to quote the gentleman from the film. Thank you for sticking with us and asking some incredibly good questions. I'll ask you to fill

out that blue evaluation form before you leave. Make a note of the Medicaid primer on March 1st on your calendars and ask you to join me in thanking both the Kaiser Family Foundation for its co-sponsorship and support and our dedicated and very insightful panelists for their explanations of some tough questions. [Applause]

[END RECORDING]

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