ALLIANCE FOR HEALTH REFORM

“Inside Deficit Reduction: What it Means for Health Care”
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ED HOWARD: Alright, thank you for your patience. My name's Ed Howard, with the Alliance for Health Reform. I want to welcome you on behalf of our board of directors and Senator Rockefeller to the first in what will be a four part series of briefings on the deficit reduction work that's now begun here in Congress.

My apologies for the slight delay and for the crowded conditions and actually in absentia to those of you who couldn't get into the room at all. In fact judging by how fast the registration filled up to the capacity of this room, this may be the most popular briefing we've had in the 20 year history of the Alliance's hill briefings.

You'll notice some other distinguishing features about this briefing as well including the fact that although it's not completely on schedule, we are starting early. We're going to run a little longer than you're used to. That's to let us cover several different aspects of this issue.

If you look at the agenda, you'll see that there are three distinct divisions. First a factual look at the mechanics of the process agreed to last month by Congress and the President. Second, a look at the dynamics of the process from some folks who understand how D.C. process works generally

and finally, a look at the political implications of deficit reduction and the impact of politics on that process.

And unlike our normal procedure, you're going to get a chance to ask questions after each of these segments thought not for as long as normal. And as I said, this is the first of four deficit reduction briefing. We're going to hold one focused on the implications for Medicare next month. One on the implications for Medicaid in November then on— then in early December, we're— once the deadline for action by the super committee has passed, we'll take stock in a final session.

We couldn't have organized this series without the support and the involvement of our co-sponsors. And that's a little unusual too. We have four co-sponsors for all four of these deficit reduction briefings; the Robert Wood Johnson Foundation, The Commonwealth Fund, the SCAN Foundation and of course, the Kaiser Family Foundation. You'll find a little bit of background on each of them in a single sheet that may or may not have made it into your kits. We put it together fairly quickly but take a look at it. I want to thank every one of them. They not only recognized the importance of this series of briefings to inform you, they did it in record time so that we could get off the mark in a timely way.

I'm not going to spend a lot of time introducing the subject. We have a lot of people on the program today including my co-moderator who are a lot better versed in the nuances of these issues than I. But I do want to emphasize one point. There's a very small margin of error if both sides are going to come to an agreement that will ease the fiscal tension around deficit reduction. And let me see if we've got one here.

It may not be as dramatic as this cartoon depicts but the window is pretty narrow. If you can't read it, that's what it says room for negotiations in the middle of the cannons. So, we do have an interesting and challenging task. And I want to turn at this point, if I can, to my co-moderator, Diane Rolland who is, as most of you know, the executive vice-president of the Kaiser Family Foundation, the executive director of its Commission on Medicaid and the Uninsured and the chair of the new MACPAC created in the Health Reform Law, the Medicaid and Chip Payment and Access Commission. I'm very pleased to have you with us, Diane and look forward to your remarks.

DIANE ROWLAND: Well thank you Ed, and thank you to all of the Alliance for pulling together this series. I think that it really represents an important opportunity for us to learn

stake in the various proposals that may come forward. But I especially want to compliment the Alliance on their ability to pull together such a stellar group of speakers as we have today. And I think all of you for being here is really a testament to how wonderful this panel is.

So without taking time from the panel, I just want to thank Ed and the Alliance for pulling this together. On behalf of the foundations that are supporting it to say that this is really a very important time for us to keep in focus the implications of policy changes for the millions of people on Medicare and Medicaid which will be the focus of many of our future discussions. And we look forward to the panel today. And also to trying out a new format which I think will be perhaps constructive for future sessions as well. Thank you.

ED HOWARD: Thank you Diane. A couple of few logistical items, you know you have materials in your packets. Tomorrow you can tell your friends who didn't make it in the 90 minutes the registration was open that there'll be a Web cast available on the Web site of the Kaiser Family Foundation, kff.org, tomorrow. And you can get copies online of all of the materials that you have in your packets at the same time. Later on, there'll be a transcript on our Web site at allhealth.org.

You'll have a chance to ask questions, as I said, after each of the segments of the program. And there is a blue evaluation form in your kits that I hope you will fill out at the right time. We are continuing our pay for performance program that will allow you to trigger a $100 contribution to Unity Healthcare here in the district if we get to the threshold of 50-percent of you filling out the evaluations. So, peer pressure, make your buddy fill it out as well.

Let me turn to something that– it's a good thing I don't need notes to say because I can't find my notes. Katherine Hayes is going to walk us through what this stuff all really means. Katherine is at George Washington University. She runs the GPS Project that tracks health reform on a unique and very useful Web site. She has spent years and years working for legislators– senior legislators on the Hill, both Democrats and Republicans. We think she's uniquely suited to presenting this information in as lucid and balanced manner as anybody I know. So Katherine thanks for being with us.

KATHERINE HAYES: Thank you very much, Ed and thank you Diane and to all the funders for making this possible today. It's great to be here. When you talk about having a good knowledge of the budget process– I was talking to Bill Hoagland a little bit earlier and I did health issues on the Hill. And

budget issues. And I keep waiting to get an email from him saying look, what do you know about the budget. All you know about the budget is how to spend money not to save money.

So, with that, I do teach a course at G.W. in the Department of Health Policy, a seminar on the Federal Budget Process. And I suspect that was one of the reasons I'm here today. You know it's important to think about this in terms of when you think about the Budget Control Act and you sit down and try to read it, you know it's impossible for just a common— just a lay person even an attorney to sit down and read it and try to figure out exactly what it means in healthcare. And so I think this is really important. You really do need to sit down with the Budget Control Act and with a copy of Gramm-Rudman-Hollings. And it's immense. And so rather than doing that, I'm going to try to give you sort of a lay person's view of the Budget Control Act and what it means.

And so I want to have a— I want to say a disclaimer first of all that a lot of this is somewhat ambiguous. When you look at the language, particularly when you get down to some of the sequestration provisions and I know there are a lot of folks in the room, particularly those with CRS and those who have a lot of experience on the budget. So, first I would ask tolerance for those if I'm going at a level that you already

know. But I'd really like to back it up just a little bit to make sure that everyone is following what's going on here.

So first of all, I want to just very quickly note the distinction between discretionary spending and directed spending. I think that's really important.

When I talk about directed spending within the context of the Budget Control Act, what I'm really talking about is annual appropriations and those programs that are funded through the annual appropriations process. Those are the programs that if Congress fails to do something about by September 30th of every year, the agencies shut down. It's the operating budgets of the individual agencies, grant programs within the agencies. When you talk about the Department of Health and Human Services, a lot of the provisions within the Public Health Service Act, funding for NIH, generally those are the types of programs that we're talking about.

When we talk about directed spending or mandatory spending, we're talking about Medicare. We're talking about Medicaid, the Social Security Act and some other provisions there. So I just sort of wanted to lay that out first of all.

Now the Budget Control Act contains five major titles, only four of which you really need to worry about unless you are working in education. The first is the debt ceiling. The

balanced budget amendment vote. Third, the Joint Select Committee on Deficit Reduction also known as the super committee and I will probably refer it to both— refer to it in both ways during the course of my remarks here today.

Another thing that's really important that you need to think about is the enforcement provisions for both the discretionary spending and for directed spending if the super committee fails to reach an agreement. And I'll go into that just a little bit more. And finally there are the education provisions there.

So I thought I would start with the easiest piece of this which when you think about it is kind of humorous which is the debt ceiling increase. [Laughter] So, first of all, the original legislation allowed for an initial $400 billion increase in the debt ceiling once the president certified that the— we were within $100 billion of reaching the ceiling. And that happened on August 2nd of 2011. So within 50 days of that, the president has— also has the authority to certify an additional $500 billion. And the date, if I am counting correctly and I've never really been good with math but I pulled out the calendar, it should be September 21, 2011.

Now this goes into effect if the president certifies that we are within $100 billion of the debt ceiling. Then this

disapproval by Congress. And we know now that that's not going to happen. There was a vote last Thursday. It was on SJ Reg— S.J.RES.25 which was introduced by Senator McConnell from Kentucky. And there was a motion to proceed to consideration of the resolution which is just a fancy way of saying, you know, it failed. They weren't able to get enough votes to even bring it to the floor for consideration. And it failed 45 to 52. So we know that that second installment when the president certifies it is going to go into effect. And that will take the debt ceiling up another $500 billion.

So then it starts to get a little tricky. So if— there are several scenarios here. Congress is authorized to— Congress has authorized the president to certify and to allow the debt ceiling to go up another $1.5 billion, a maximum of $1.5 billion. But there are a lot of contingencies here. One is the super committee which I'll talk about in a minute. If the— if nothing happens at all, if the super committee fails to do anything then there will be an additional $1.2 billion. So the pressure's sort of off their— trillion. Sorry I keep saying— billions and trillions, you know? [Laughter]. It's all funny money, isn't it? So $1.2 trillion; I even have it wrong in my notes here.

So a $1.2 trillion in deficit reduction. And if— so if

approved. If the super committee comes up with a figure that's less than $1.2 trillion that'll be approved but if they come up with an amount that is greater than $1.2 trillion in deficit reduction then the debt ceiling will raise commensurately with the amount that they save up to a cap of $1.5 trillion.

And then finally if they pass a constitutional amendment to the balanced budget then they can raise it another $1.5 trillion. The president can certify again. And it is subject to a joint resolution of disapproval. And if those pass— if that passes for the final step then the president, of course, would have the ability to veto it and that could be overridden by Congress. So are we crystal clear on the debt ceiling? So bottom line, it doesn't look like we're going to have another standoff in the short-term. So things are okay for now; so just rest assured, sleep at night at least for the next few months anyway.

Okay. Now let's talk about the balanced budget amendment which is another sort of easy part of the Budget Control Act. Which is Congress is required to vote on the constitutional amendment to the balanced budget between October 1st and December 31st of this year. Now whichever house takes it up first, there are no special rules for consideration. But the second house that takes it up; there's an expedited process

watch how this happens. But again, if both houses approve it, the debt ceiling can be increased by $1.5 trillion.

So, okay, now let's talk about limits on discretionary spending. This is where it gets a little complicated. So it helps me to really think about this in two different respects. One is you know the first thing that the Budget Control Act was cap domestic discretionary spending for FY 2013– no, 2012 through 2021. And if those of you who are familiar with the appropriations process, if you think of that as sort of almost a 302A allocation, this is an amount of money that the appropriations' committee will have. It has to be certified by the budget committee chair. This is the amount of money that Congress will have in each year to make all of their appropriations.

Now in the first two years, it's split between security issues and non-security issues. And when you start thinking about– I'm sure one of your questions is going to be what is security. Well it's– it includes the Department of Defense. It includes the Department of Homeland Security, the Department of Veterans' Affairs, Intelligence International Affairs and I always mess this one up, it's the NNSA; the National Nuclear Security Administration. Anyone? So anyway, it's not an agency that I have had very much dealings with in my career in

healthcare. So please forgive me if I didn't get that right. And then non-security is everything else.

So when you look at these budget caps and there is a sequestration process to enforce that too. Let's forget about the Super committee for a minute and let's forget about directed spending and what's going to go on. But we know now that we have these caps in place– these appropriations' caps that we're going to have to live under. So what happens if Congress appropriates money above and beyond the level of the caps?

Well first of all, at least in the Senate which I'm most familiar with, those can usually be enforced through a budget point of order. So if someone brings an appropriations' bill and it'll probably be toward the end of the process, if they move the bills– if they move them separately. But at the end of the year as we end this fiscal year, if the appropriations' bills that are going through Congress start to push up against that cap, you're going to hear a lot of talk about that and see some folks objecting on the floor raising a budget point of order on the Senate floor against these appropriations' bills. And that could cause some problems.

But if that does not happen, there's also a sequestration process for across the board cuts in domestic

exceeds these caps. So think of that cap sort of separately. Those are the appropriations' caps that can be subject to sequestration. And sometimes when I've heard this described, they tend to get muddled together a little bit. But this'll be really important if in fact the super committee does pass a deficit reduction package. Just keep in mind that these appropriations' caps— the domestic discretionary appropriations' caps will still apply.

So, let's talk about the annual enforcement or maybe we should talk about— I think I already did that. Let's talk about the Super committee a little bit. So it's the Joint Select Committee on Deficit Reduction. Now the legislation, if you read it or the law if you read it, tells them that they need to save $1.5 trillion over the next 10 years.

And, but the number that you're really hearing a lot is $1.2 trillion not $1.5 trillion. So you're probably wondering a little bit about what the discrepancy is there. But just know that they can come up with an amount that is anywhere between $1.2 trillion and go up to $1.5 trillion but still won't be subject to sequestration. If they don't quite meet the $1.5 trillion amount, there will be no sequestration. But if they are— if they come in less than that, there will be. And we'll talk about that a little bit in a minute.

There are expedited procedures for virtually everything in this bill. There are separate expedited procedures for consideration of the super committee proposal, for consideration of the debt limit votes. So it's just important for you to know that filibuster, by and large, will not apply. So keep that in mind as well.

If there is no deficit reduction enacted by January 15th of 2011 and that's a minimum of $1.2 trillion, automatic spending reductions go into effect on January 2, 2013. Yes, I did say 2013 not 2012– 2013. So that gives Congress a year to intervene and keep these cuts from going into place.

Alright, let's talk a little bit about the super committee deadlines. There is a provision– I mean there is something in your packet– a document I saw in your packet– that had all of the deadlines in it that you can use. It's– I think it's the RNC or– let's see. The Republican Study Committee; it lays out all the deadlines.

The ones I'm going to go through. The first one was the August 16, 2011 appointment of committee members. That's already happened. And I'm sure you're– we can talk briefly about them but I don't think we need to go into a lot of detail about that. And they had to meet. Their first committee meeting deadline was September 16th of 2011. And that has

already happened as well. They met last week for the first time.

So, September 14th will be the next date in terms of the Super committee. The Republican Study Committee also includes a lot of the other procedural deadlines. But I'm sort of— I'm sticking to the super committee for now. So on October 14, 2011, the House and Senate committees of jurisdiction may make recommendations to the Super committee. So you may see members of the House Ways and Means Committee; House Energy and Commerce Committee; Senate Finance Committee and other committees to the extent that they can get agreement. And I understand some members will be sending comments separately. I have heard that perhaps Senator Hatch may be sending recommendations separately on behalf of Republican members of the committee. But that— the date by which the committee has— the committees of jurisdiction have to send members to the Super committee are October 14th.

By November 23rd of 2011, the committee members must vote on a proposed deficit reduction legislation and report that legislation. So November 23rd. So there's some interesting rules that apply to the Super committee too that we don't typically see in— do I just have a minute left? [Laughter]. Okay. I'll go quickly.

ED HOWARD: The Chair will recognize the general woman for an additional—

KATHERINE HAYES: Okay. I will— I will—

ED HOWARD: —three minutes.

KATHERINE HAYES: Okay. I will move quickly. Never mind about the interesting rules of the super committee. You don't really need to know that. [Laughter]. On December 2nd, if it's adopted and I won't even go through these because you have them in your proposal. So, we're skipping over the members because you all have access to the press and you know who those are.

And then let's finish up here with the deficit reduction fall back and talk a little bit more about this. So if the super committee bill is passed by January 15, 2012 then we will see those go into play. We will see whatever changes they make go into place plus remember the domestic discretionary caps still remain in place. But there's nothing that precludes the super committee from making changes in those caps. So keep those in mind. They can make changes in revenue. They can increase taxes. They can make cuts. You know although the super committee— the sequestration and I'll get to that in a second. There are certain exempt programs. The super committee can make reductions in Medicare and

Medicaid beyond those limited by sequestration. They can also make changes in the health reform proposal as well.

The automatic spending reduction's amount of $1.2 billion or any short fall, if the committee for example only comes up with $900 billion in savings then the sequestration will apply to the difference less net interest on the debt. So, and it will be divided into both— also if they don't go into effect, the discretionary caps will be revised. And they'll be split equally between defense and non-defense. And notice that's a little different than security and non-security. As I read it, it looks like they define that differently once— in the first two years for the domestic discretionary spending caps. I'm getting a nod from Bob so I have that right.

But in the first two years, there's a difference between security and non-security and the domestic discretionary spending caps in the appropriations. But if they fail to meet the $1.2 billion deficit reduction target, those deficit caps are renegotiated. They're spread throughout the life of the deficit of the— through the 10 year period and will be defined between defense and non-defense. Which as, if I remember correctly, has functioned 50 of the budget not that anyone probably cares but. Okay. Then there'll be a

proportional division between discretionary and direct spending. So it, both Medicare and appropriations will be hit.

In the sequestration however, certain direct spending is exempt. And those are the provisions that we have seen and that we dealt with in Gramm-Rudman-Hollings which I think is Section 255 of the Budget Act if— if you want to take a look at that. But they do exempt Social Security, Medicaid and Medicare is limited to 2-percent. And the spending reductions, as I noted, will begin January 2, 2013.

And I was asked also to give you a brief on the history of sequestration. I guess in the no minutes that I have left I will say that sometimes it has worked, sometimes it hasn't. [Laughter]. So thank you all very much. And I apologize for going a little over. This is much—

ED HOWARD: That's the best summary of the sequestration device that I have ever heard.

KATHERINE HAYES: Yeah. Well I just keep remembering last time I was here, I was asked to explain the Administrative Procedures Act in 15 minutes or less [inaudible].

ED HOWARD: Stay put if you would for just a couple minutes. We promised to give you a chance to ask questions but I would ask that the questions be limited to the kinds of clarifying questions that you might have as opposed to trying

to argue with Katherine about whether something ought to be in that or not. Yeah, I— [Interposing]

KATHERINE HAYES: And I won't be at all offended if there's someone here who knows a lot more about this than I do that would like to clarify. Because it really is technical and there is a lot subject to interpretation here I think.

ED HOWARD: And I would urge you not to use your green cards to— but to go to the microphones so we can get them. I— Katherine, one thing that occurred to me as you were talking about the super committee having the power to make changes in the Affordable Care Act and that is do they— do those changes have to have a budget impact? I remember when they were enacting the ACA; there was a lot of talk about not being able to take up things that didn't have a budget impact. And I'm not sure if I got that right because Bill Hoagland is shaking his head no.

KATHERINE HAYES: Well it— you know those are subject to reconciliation instructions. And this isn't reconciliation but there are no amendments in this process. So I think they can pretty much do anything. As I understand it, there are no limits. They can do pretty much whatever they want as long as they come up with $1.2 or $1.5 or even less. So, revenues are on the table, everything.

ED HOWARD: Any other clarifying questions for Katherine? Well that is a tour de force.

KATHERINE HAYES: Okay.

ED HOWARD: Thank you very much. And we'd like to ask our next panel to come for– you'll get another chance to ask Katherine questions at the end if you will. I'm going to take advantage of the time while our panel is coming up and the stairs are over here to give them the merest of introductions. Bill and Gail over there, I think we have Bob here. I was making it easier for you– Gail to come in late because I thought we would come in this way.

GAIL WILENSKY: Yes. Thank you. Good thing I didn't come in as late as I thought I would.

MALE SPEAKER: You want me to sit here?

ED HOWARD: Yes sir. Thank you. As promised, you're now going to hear from three extremely well respected Washington analysts. We're going to start with Bill Hoagland who's the vice-president of public policy at CIGNA and the former staff director of the Senate Budget Committee, former budget advisor to then senate majority leader, Bill Frist and a member of the Dominic– Dominic Rivlin Deficit Reduction Task Force of the Bipartisan Policy Center that reported late last year.

Bob Greenstein, to my immediate left, is the founder and president of the Center on Budget & Policy Priorities. He's a former administrator of the USDA's Food and Nutrition Service in the Carter administration and the recipient of the MacArthur Foundation's, so called, Genius Award.

And at the far end is Gail Wilensky, a health economist extraordinaire and senior fellow at Project HOPE, senior advisor on health and welfare issues to President George H. W. Bush and a former administrator of what is now the Center on Medicare and Medicaid Services.

All deserve better introductions than that but we want to get started and give them as much chance to talk about what they see as the important aspects of this process as we possibly can. And Bill, we've asked you to kick it off.

BILL HOAGLAND: Is this on? Yeah. Katherine didn't get a chance to talk about the powers of this special committee. And I thought it was appropriate for a group of 12. I think they have apostolic powers. [Laughter]. There's no question in my sense that the author is authorizing authorities that are granted under this act to this committee are broad. They're unique and even somewhat, I believe, unprecedented.

In less than five minutes, Ed asked me to provide the setting for this Joint Select Committee and with a focus on

without the crutch of some PowerPoint slides is maybe a challenge but bear with me.

First of all, as everyone I think is well aware in this room, the level of debt and deficits that are at historically high levels. The deficit for the current fiscal year that will end in a couple of weeks here will reach nearly $1.3 trillion or over 8.5-percent of GDP. And that's four times the average annual deficits over the last 40 years.

And the real concern, highlighted of course by the debate that we've had over this last summer that led to the establishment of this special committee is the fact that debt held by the public, that's debt going back to the founding of this country, accumulation of debt sought from the beginning minus the surpluses, will reach over— close to 70-percent— 67-percent of GDP. And that's almost double the historical level over the last 35 years.

It's unprecedented except for the period immediately followed World War II. But then remember after World War II that debt we owed to ourselves not to 50-percent of the foreign entities that are out there.

And while an extension of current law policies and boy, I assume we may get some questions about the baseline. But if you assume the extension of current law policies, meaning that

reduction goes into effect. It is in— it is true that it's possible that the picture improves rather dramatically that deficits come down to about 2.5-percent of GDP and— but debt to GDP remains at about 60-percent.

And if you do not assume that then we have a real problem where the debt to GDP is going to continue to grow under what we call the alternative baselines where you don't assume those expiring tax provisions and you don't assume the 30-percent cut in Medicare reimbursement rates under SGR. We're up around about 115 - 120-percent unprecedented.

So within this framework, what is the challenge that is confronting this select committee and how will it impact healthcare spending? I think the president, himself, made it very clear last Thursday night when he addressed the joint session that healthcare spending is what is driving federal expenditures. Now we all know, I think, in this room very broadly that over 55-percent of all federal spending falls into that category considered mandatory spending and entitlements.

Now I would argue that the Budget Control Act has for all practical purposes and Katherine made this point about the appropriate accounts that that portion of the budget, that 55-percent of the budget is entitlements. If you add in interest, we're up to about two-thirds. That latter one-third I would

agreement. The caps for these accounts that Katherine talked about are effectively— will have an annual rate of growth of 1.2-percent over this next decade. And in real terms that means after adjusting for inflation, it's negative growth in those— on those accounts.

And I consider those accounts to be the seed corns' accounts for federal investments in science, NIH education, research, community healthcare centers and infrastructure. So that leaves the entitlements. The term entitlement reform rolls off the tongue so easily but let's be honest about what we're talking about. If I can the nearly $26 trillion in entitlement spending over the next decade and if I remove from that Social Security spending a sense it will be extremely difficult as most people know to protect current retirees or near retirees. If I take them out then I think you will find that 80-percent of all entitlement spending over the next decade is related to healthcare programs and obviously predominantly Medicare, Medicaid and the subsidies on the new exchanges.

Let's be very clear except for net interest on the public debt, the fastest growing component of the federal budget over the next decade are mandatory healthcare programs growing from 6 to 9-percent annually. Almost double the

But here's the rub and I think later on this afternoon, Chris Jennings and others may point out. If the select committee fails to reach an agreement and so called sequester kicks in as— in 2013, except for the fact that there's a 2-percent maximum reduction in Medicare and the fact that Medicaid and the low income entitlement programs will be exempt. That means that these programs that make up 80-percent of all entitlements and represent the fastest growing components of the federal— of federal spending would contribute less than 12-percent to that $1.2 trillion target or slightly more for the $1.5.

Even if revenues somehow could make up half of the $1.2 trillion target, if Medicare, again, were limited to 2-percent and no reductions in other healthcare programs, they would still represent less than a quarter of the reductions from a pot that, again, represents 80-percent of all non-Social Security entitlements.

A lot of numbers, sorry, but the simple point I am trying to make well there are those I assume in this audience that might take the position it is better to accept the devil I know 2-percent reductions in Medicare, no cuts in Medicaid from a sequester than the devil I do not know which might come out of the select committee. I believe that that would be very

country's fiscal future let alone the ability to provide affordable healthcare in the long-term by controlling costs. So I'll stop there.

ED HOWARD: Thanks very much Bill. We'll turn now— yeah— we turn now to Bob Greenstein. But you don't want that you want that.

BOB GREENSTEIN: Do I have this on?

ED HOWARD: Yeah.

BOB GREENSTEIN: Thanks everybody. As the end of Bill Hoagland's comments indicated, the work of the joint committee presents a particular challenge for healthcare. It also presents a big conundrum. On the one hand, it's generally agreed that the biggest contributor to our long-term deficit problem is rising healthcare costs throughout the U.S. healthcare system. But on the other hand, it really simply isn't possible to get large savings out of healthcare programs in the next 10 years on top of those in the Affordable Care Act without some really draconian changes for two reasons.

Reason number one; in the case of both Social Security and Medicare, we effectively have a bipartisan agreement not to hit current beneficiaries hard. Take the Ryan budget; it actually had no savings in the first 10 years in Social Security and only modest saving in Medicare. It's very

until the second decade outside the window of the joint committee's target applies to.

Number two; the increase in costs in Medicare and Medicaid and in pro-beneficiary costs in particular is driven by two things. Number one the aging of the population, older people have much higher average healthcare costs than younger people. There's nothing we can do about that. I don't see any bipartisan agreements on some kind of death panels.

And— [laughter] secondly, of course, the other factor is system wide healthcare cost growth. There is nothing out of line in Medicare and Medicaid cost growth relative to the rest of the healthcare system. In fact they're relatively well behaved in recent years compared to the rest of the system.

The first slide shows you that over the past decade Medicare and Medicaid cost beneficiary have avid— have risen at a rate that, as Bill notes, is unsustainable over time but it's actually slower than the rate at which private sector costs are growing. And the second part that just adds to the difficulty is Medicare and especially Medicaid already cost less per beneficiary than private sector care.

Here's a slide from well known studies showing that, of course, Medicaid cost significantly less than private sector care. Medicaid and Medicare generally pay providers less and

Now this raises something that's pretty inevitable when the joint committee begins to look at options. They will inevitably end up looking at options that save money in Medicare and Medicaid by shifting costs to other payers rather than constraining them to states, to employers, to beneficiaries. The problem is that proposals that shift costs do nothing to reduce system wide healthcare costs and may even raise them.

We're concerned about deficits in the first place because we're concerned about what that does to the economy over the long-term. But simply shifting healthcare costs from public payers to other public or private payers does nothing to lessen the overall burden that healthcare costs place on the economy. More over and this just adds to the difficulty for the joint committee, a number of proposals to save the federal government money by shifting Medicare or Medicaid costs don't just shift costs, they actually increase total system wide costs.

Now a number of you are probably familiar with the data in the next slide which are all from the CBO analysis of Paul Ryan's budget plan. As CBO noted, moving to the vouchers that Ryan proposed, CBO estimated would increase total costs per Medicare beneficiary for those affected starting in 2022 by

nearly 40-percent from a little under $15,000 per beneficiary to over $20,000.

What isn't as well recognized but is shown in a recent Kaiser Family Foundation study is that the proposal to raise the Medicare age from 65 to 67, much talked about, would have the same result. The Kaiser study indicates that for every dollar it would lower federal Medicare costs; it would increase costs that other payers pay by $2. The other payers being state governments, employers, beneficiaries and actually Medicare ben– and other Medicare ben– excuse me– other enrollees in the health insurance exchanges whose premiums would go up as well as other Medicare beneficiaries whose premiums would go up as well.

This is the reason why there was unusual development for those who weren't on vacation and noticed it on August 22nd when Ezekiel Emanuel, former health advisor to the director of OMB and Jeff Liebman, former executive associate director of OMB, neither of them thought of as big flaming liberals or with ties to AARP or anybody like that, published an article in the ***New York Times*** basically saying that raising the Medicare eligibility age would be a very unwise idea precisely because it would increase total healthcare system wide costs.

Moving into the Medicaid area, the joint committee is

ability to use provider taxes as a way to finance the state's share of Medicaid costs. There also are proposals around to change Medicaid and CHIP matching rates through a so called single blended rate. But the blended rate only saves money by setting it at a lower level than what the current array of matching rates provide the state governments. Both the provider tax and the blended rate, you can make other arguments for or against them. Fundamentally they're both cost shifts. They don't lower costs. Once again, they shift them to states.

So this just adds to the conundrum, to the difficulty the joint committee faces. I do think there are some proposals that aren't cost shifts and that probably can pretty readily secure bipartisan agreement. For example the proposal to modify the definition of modified adjusted gross income under the Affordable Care Act that applies both to the subsidies and the exchange and Medicaid if the treatment of Social Security is changed that produces savings. But those saving are all of $13 billion over 10 years; they're not where the big money is.

There is bigger money in other proposals arranging from securing the kinds of saving for dual eligibles, low income beneficiaries and Medicare, the kinds of savings from pharmaceutical pricing that Medicare used to get or from restructuring cost sharing and in particular ending the ability

But both of those are highly controversial to say the least. Personally, I hope both of those are carefully looked at but I'm not holding my breath to have them come through with extremely large savings.

All of this, what I refer to as the conundrum, is the reason why over the past year both Martin Feldstein, former chairman of President Reagan's economic advisors, conservative economist at Harvard and Peter Orszag, formerly at OMB now at Citi, both published articles basically saying that in the long run the major deficit, the lion's share or the majority of deficit reduction, needs to come from slowing entitlement growth particularly in healthcare but that there really aren't good ways of getting big savings there in the next 10 years. And therefore, that all of the Bush tax cuts not just those for people over $250,000 should be allowed to expire on schedule to get us enough saving up front to stabilize the debt in the coming decade and to buy time for the much larger savings we're going to need in the long run through more fundamental system wide reforms in how we deliver and pay for healthcare in the United States. But of course, the chance of the joint committee considering that is— I'm almost tempted to say it's less than zero if such a thing were mathematically possible.

Let me close on the following note, Ed mentioned that

proposed a deficit reduction plan that had— was 50/50, one dollar in revenue for each dollar in spending cuts.

The Bo Simpson Plan and the Gang of Six Plan were 2 to 1; two dollars in spending cuts for every dollar in revenues. Both plans counted within those ratios the discretionary spending cuts enacted as part of the budget— enacted in any form and therefore, if one's looking at where we're heading, you include the discretionary cuts just enacted as part of the budget control line.

I bring this up for the following reason. If one set is a goal not the 1 to 1 in Rivlin Domenici but the 2 to 1; two in spending for everyone in revenue in both Simpson and Gang of Six, the two plans that are bipartisan that had current members of Congress on them. Then once you count the discretionary cuts enacted last month, what you would need in the super committee is about equal spending cuts and revenue increases for the total to be 2 to 1; each dollar in spending cuts would have to be matched with a dollar in revenue and vice versa.

If one did that, I believe one could hit the target with savings that don't involve massive cost shifts. There would be pain for sure in healthcare and other areas. Everybody would suffer but you could get there. However, if there are little or no revenues agreed to in the joint

fail. Because the only way to hit the joint committee target without sig— for the next 10 years without significant revenue really is through changes in Medicare and Medicaid, that in my view, go far beyond anything that can be justified that involve huge cost shifts and inevitably very large increases in the ranks of the uninsured.

I completely agree with Bill that the sequester for— the sequester that occurs if the joint committee fails is really not good policy as a way to reduce the deficit. I would argue that in my view an unbalanced plan coming out of the joint committee with little or no revenue would be even worse policy than the sequester would entail. So the hope is a balanced plan out of the joint committee.

I would end by noting that if the joint committee doesn't hit the target, either fails or comes in well short, that does not necessarily mean that we'll simply have these sequesters. I think what will then happen is we'll have a debate through all of 2012 and that in the lame duck session after the congressional election with the across the board cuts looming, there will be another effort to see if we can get a bipartisan deal.

If that fails and automatic cuts do take effect in January 2013, we do not get $1.2 trillion in cuts. We get

hundred billion that with interest give you the $1.2. It is my view that if we get so far as to have the first year of automatic cuts take effect that the results will be so unpalatable that we will get some kind of an agreement at least in 2013 to make sure the second through ninth years of the automatic cuts don't happen. Thanks.

ED HOWARD: There you go. There's your scenario. Gail Wilensky has seen a lot of efforts to hold down healthcare costs come and go. Gail, is this one going to come or go?

GAIL WILENSKY: Bottom line which was in a piece that Kaiser published in July, it— is that it's hard for me to see really significant changes until after the election in 2012 because there is a fundamental disagreement about how to go about achieving the kinds of savings that would be required. That's a good lead in. Actually I want to comment on two sets of numbers that Bob just used and the second will also lead me into a major I want to make with regard to the issues we're going to face when we look at healthcare and particularly Medicare.

The point is that it depends very much on exactly which numbers you look at as to what you see but some of the bottom points are worth noting anyway. I'm saying that with regard to the slide that showed private sector spending growing at a

than public sector spending. If you looked in even the 1990's or in the projections by CMS for the next decade that has actually flipped.

His bottom point and I agree with this point, is that what goes on in the public program particularly Medicare and private or total healthcare spending, rarely deviate very much over any significant period. But I think it's really wrong to say any way the public sector is doing better. As I said, if you look at the adjacent decades on either side, they actually did worse. But the point and it's going to become even more true as the baby boomers age because Medicare and Medicaid and with the Affordable Care Act becomes an even bigger part of the whole. So they can't possibly move away from each other for any long time.

The second thing is I want to comment about the CBO projection about the Ryan plan because it's going to lead me to the main points I want to raise with regard to the potentials that are out there with regard to slowing healthcare spending. And that is that there are two very important assumptions. There's actually probably a lot more assumptions but two very important ones to note.

The first is that CBO assumes that the major change incentives that are embedded in the Ryan proposal don't

And so the question is; how are you going to fund the same package, the same expenditures that would be out there going 2021 and going forward?

Now that is going to be one of the major issues is whether or not you believe if you change incentives in a significant way, will you actually change total spending or not? I will say that if you think not, we are in for a very bad time in healthcare. I'm not part of that group but that is a fundamental question.

The second assumption that was made is that any of the short fall on spending in the public sector will get fully shifted to the private sector. And you can decide whether you buy into that or not. The bottom line for me is many— the basic message of the CBO analysis of the Ryan plan was completely predictable given those assumptions. So I— there are many parts of the Ryan proposal I would want to see modified but I just think you need to understand that when you look at that estimate. But as I say, it really raises the fundamental question for what we can do going forward.

If we look at our past attempts in Medicare to try to slow down spending, they have one been entirely focused on providers. And number two; they have primarily resorted to reducing reimbursement within the current reimbursement system

seen over time an attempt to change the incentives in reimbursement with a move to more bundled payments which has happened in hospitals. It's happened in home care and it's happened in nursing homes. It's importantly not happened at all in physician payment.

Now the reason this becomes so important to think about is that if you believe the only way to get saving reductions in Medicare is to use the system we have now and pay less, this is going to be a really ugly picture. Now most of us most of the time who deal in healthcare think we could do much better if it was reorganized, if you could find ways to change the incentives that are a part of our current system. And so one of the questions is; how serious are we? What are we going to do to go about making that happen? I agree completely with Bob who says, as have others, that it's going to be hard to get a lot of savings in the short-term from doing that. But you want to be careful in trying to get short-term savings that you don't undercut any possibility for really changing the incentives in order to be able to deliver better quality care at lower spending.

The second major question is; will we only continue to focus on providers or will we also look at providers and beneficiaries at the same time? And to me, this is really the

with the Ryan plan with a whole bunch of modifications to it, is an attempt to change the fundamental incentives that the beneficiaries face in addition to leaning hard on the providers. Congress has never been willing to do that. And whether or not that will change going forward we'll have to see.

Value based insurance where you have varying co-payment depending on the likely clinical outcome. Value based purchasing, fixed dollar premium support with all of the understanding that it depends on how you determine what that fixed dollar of premium support is. This is not going to be easy and current law as it regards the SGR makes no sense. We have all the power that Congress needs in place in order to limit Part B spending. It has carefully avoided using it except once in the last decade because the current system is so patently unfair in doing so would indiscriminately hit the good guys and the bad guys. There is a reason healthcare spending in Part B has been growing several times faster than the very small unit increase in reimbursement. And trying to fix this is going to require changing the way we reimburse physicians.

But it really then does come back to one, what do we do to buy ourselves out of the short-term problem? There are some things that we could do to help ourselves. And the biggest

going after changing incentives for providers, changing incentives for the beneficiaries as well and how do we make that happen when it doesn't help us out of our current environment? Maybe what we do in our— to help us out of our current environment makes it even worse.

I've been concerned that the heavy reliance on reductions of Medicare reimbursements under this same dysfunctional system in terms of the financial incentives to fund the Affordable Care Act that was the majority part of the funding is already going to make this more difficult in the out years. And that's something that I think that the Congress, particularly those knowledgeable about healthcare will really have to worry about it.

But doing that before the next election is just— it seems hopeless to me because you have a fundamental difference of opinion between how the Republican dominated House believes it should be approached. Even the strong minority Republicans in the Senate and where they are relative to the White House, getting active movement even if you have a clear statement by the public in terms of what they're willing to consider will not be easy. But it makes no sense to me to think that we could really engage in serious fundamental entitlement reform before we have a clearer statement from the population about

is not very encouraging on this. They don't want to consider anything.

ED HOWARD: Okay. The table is set. Once again, you get a chance to ask any of the panelists questions that occur to you not just about the mechanics of what they're talking about but about policy implications thereof. And let me make sure that Diane is ready to jump in at your convenience as well.

You have green question cards. We didn't think to put more than one but we'll accept them on any kind of paper you want. And there are microphones right here and right there where you can prepare to ask your question verbally. If you do that, identify yourself, keep your question as brief as you can. And, if you use a green card, hold it up and someone will come by and bring it forward.

Okay. Let me start by going back to something that, I guess, Bill mentioned and Katherine alluded to. And that is the question of what gets counted when you talk about cuts of a certain magnitude. It's cuts from what? And, the— our keen sounding description of what's in the baseline seems to me to be pretty important in the level of change you're going to have to have coming out of the super committee or any other of these processes. And I wonder if folks could offer some perspective

on how that question gets decided or if it's been decided already? And how we might go forward with that.

BOB GREENSTEIN: The difficulty here is the baseline is whatever the Joint committee decides it is. The law does not indi— determine which baseline is be used. And the joint committee will have to decide that.

ED HOWARD: Okay.

BOB GREENSTEIN: Nor do you have a baseline that assumes that SGR relieve is made permanent or that you have to pay for the relief every year. Do you have a baseline that assumes that all the Bush tax cuts expire? The tax cuts for people under 250 are made permanent; all of the Bush tax cuts are made permanent? All of that is entirely up to the joint committee to decide which baseline it wants to use.

BILL HOAGLAND: I just want to not disagree entirely, Bob, but just a clarification. The law does say that the congressional budget office shall use very specific citing the legislative language that ties it back to the current law baseline. It says the congressional budget office shall provide estimates based upon that baseline. I agree that however the committee could decide whatever baseline they want to use. But at a minimum, the initial estimates will be done off a current law baseline.

BOB GREENSTEIN: I'm going to somewhat disagree with that. We've done a very detailed textual analysis of this provision of the law. It is a little contradictory. [Laughter]. Bill is absolutely right that it says the congressional budget office shall do an estimate using current law as the baseline. That's almost certainly not going to fully be the measure the joint committee uses because the current law baseline for revenues assumes all the Bush tax cuts expire at the end of 2012 for which there isn't a single member of the joint committee who favors that as a policy.

But the Budget Control Act also separately says that the Joint committee shall publish its own estimate of the amount of saving it has produced. That sentence doesn't entirely make a lot of sense if the joint committee is legally bound to use the CBO estimate. So when you read all of the provisions together, I think what it says and I hope Bill and I end up in agreement here. [Laughter]. It says that there shall be a CBO report that uses the current law baseline. But at the end of the day, I think the law pretty clearly allows the joint committee, if it so chooses, to use a different baseline in measuring what it has produced and to publish that number in what it comes forth.

BILL HOAGLAND: We are in agreement. We are in

gentlemen, the decision we've just start to have when the 12 apostles get in that room and start discussing the baseline. They could spend the whole— they could spent a lot of time on this issue. But I agree with you, Bob. We're in agreement. [Laughter].

ED HOWARD: And the first congress— or the first— the budget act point of order will be raised by—

MALE SPEAKER: Yes.

FEMALE SPEAKER: Yeah.

BOB GREENSTEIN: Could—

ED HOWARD: —somewhat.

BOB GREENSTEIN: — could I just say Bill and I were talking about— [Interposing]

ED HOWARD: But no— no, no, no, no, there— no budget— no points of order are in order.

BOB GREENSTEIN: Bill makes the key point which is— and the baseline is just a little subset of this. The joint committee can kind of do whatever. It can come up with its own baseline. It can come up with its own estimates. It doesn't have to abide by any existing points of order. It doesn't have to abide by the bird rule. It really do whatever it wants on all of those issues which is kind of extraordinary.

GAIL WILENSKY: [Inaudible] that's part of the debate

LEE PAGE: Yeah. Thank you. My name is Lee Page. And I'm with PVA, Paralyzed Veterans of America. And obviously revenues is quickly becoming the third rail especially since we are having debates here on the panel. But I guess my question is if they don't agree and we go into next year, would serious tax code reform be something as an avenue and would that help or is that going to be a conversational piece still?

BILL HOAGLAND: Can I quickly, Bob and I—

ED HOWARD: Yes sir.

BILL HOAGLAND: —are not in disagreement on lots of things. But I have another little, small disagreement that I wanted to raise. Bob said that there was a chance in zero that long-term fundamental reform could happen with healthcare reform out of this committee as well as, and I would carry this to the question your statement to tax reform. Re— I— one's— one thought— one thought— [Interposing]

BOB GREENSTEIN: —said— [Interposing]

BILL HOAGLAND: One thought is that remember how broad the authorities are that this committee has. And I would suggest to you, I hate— I've spent my career up here on process. I don't like the idea of process on top of process. But think of it this way, this is almost like a joint budget committee— House and Senate. Not only could they first meet

write— which is non-amendable, no filibusters as Katherine pointed out. They could only write effectively a reconciliation instruction to the authorizing committees to report back, let's pick a date, April 15, 2012 to meet— do tax reform or to do fundamental healthcare reform. This is powerful authorities that this committee has. And I, therefore, do not think it necessarily rules out the possibility of tax reform or fundamental healthcare reform.

GAIL WILENSKY: But that— [Interposing] makes no sense given what the Republicans would be implying which is to give— for in the case of healthcare, I'm— this is not necessarily the same argument in the case of tax reform although there may be some parts of it. Is that the Democratic Senate is not going to come up with a Medicare fundamental revision that is going to be acceptable to the republicans on the Senate and to the House of dominated Republicans. And why would you give them that kind of an instruction? Now if it's to come back after the election when it— I don't know what that will look like.

ED HOWARD: Alright, and we'll pick that— [Interposing]

GAIL WILENSKY: I just don't— I don't understand if you're going to do that, how you can do that before the election when there is a very clear difference of opinion about which direction we should go. Now as I say, I'm not going to

hold my breath that we'll have this clarity after the election but it's pretty clear we don't have it before the election.

ED HOWARD: That's an idea.

BOB GREENSTEIN: Let me largely agree with Bill on the tax reform side even though he thought he was disagreeing with me when he said it. I must have really been muddled in my remarks when I said the chance is something was less than zero, it wasn't tax reform. It was having all of the Bush tax cuts expire for everybody including people below 250. I think Bill has highlighted a very important point which could become a big controversy in the joint committee.

No matter what your views on taxes are, it's hard to imagine how a comprehensive or even a semi-comprehensive tax reform bill could be written outside the tax writing committees by the joint committee by November 23rd. So there clearly is an option which I believe will be raised in the joint committee to have the joint committee report– require as Bill indicated that by a state certain well before the election that a tax reform bill should be passed. And potentially they could say it should yield X level of revenue which depending on the revenue baseline you use might be considered to produce some savings.

The conundrum particularly for democratic members of

is agree to the following cuts in Medicare, in the following cuts in Medicaid and the following cuts in various other entitlements and maybe, maybe not a further lowering of the discretionary caps and in return— and those all get enacted now. And in return, there is to be tax reform by six months down the road that hits a certain revenue target that produces deficit reduction on the revenue side. There will be worry among democrats that they will have passed the entitlement cuts and that the tax reform will never happen. Not every reconciliation instruction has actually materialized into a law.

So that— but by the same token, it's very difficult to see the joint committee producing any revenue contribution unless it comes out of a tax reform type mechanism that broadens the base and maybe lowers the rates. So I think this is going to be a big tension that's probably going to arise. Is it acceptable to do the budget cuts now with a promise that isn't iron clad to do the revenue increases say next spring?

TONY HAUSNER: Yeah. Hi. Tony Hausner, independent consultant formerly with CMS. I wanted to understand one of the comments that Bob made. If you make changes in Medicare, increasing the age for instance or asking the wealthy to contribute more, I heard you say that that would result in

towards the overall package that the super committee has to deal with. So then I misunderstood what you had to say there.

BOB GREENSTEIN: The super committee's targets only relate to the federal budget. The conundrum that I'm trying to talk about is there are proposals that would save money in Medicare for the federal budget while increasing system wide healthcare costs.

TONY HAUSNER: Right.

BOB GREENSTEIN: The federal budget gets a certain amount of saving. The increase is born by state governments, employers and private citizens in the aggregate could be greater than the amount that the federal budget saves. But the joint committee wouldn't have to worry about that. They could just—

TONY HAUSNER: Right.

BOB GREENSTEIN: —count the federal saving towards their target. In my view, our real goal ought to be how do you constrain costs ideally—

GAIL WILENSKY: But—

BOB GREENSTEIN: —system wide rather than shift them.

GAIL WILENSKY: But those are— they're— this is one of the difficulties when you look at this so piece mill. If you think about the need to increase eligibility, not maybe to 67

to keep people in the labor force longer for a whole variety of reasons then what the look in terms of assuming basically current behavior by these individuals and what happens with regard to the cost becomes very different. Because part of what you are trying to do would require tax policy changes probably as where you— desirable that tax policy changes is to change the incentives to have people staying longer in the labor force.

Now that assumes we've done something about our unemployment situation and have been able to restart economic growth. But it's— the difficulty of looking at these in terms of one slice of a change at a time.

BOB GREENSTEIN: Let me partly strongly agree with Gail and partly strongly disagree. I completely agree that for our long-term fiscal health we need to change incentives to encourage people to work longer. But if you believe that all Americans should have health insurance and that 65 and 66 year olds shouldn't be uninsured and that a change in the Medicare age then must be accompanied by a series of other measures in the health insurance exchanges in Medicare, the effect on increasing people's work careers is going to be minimal. The only way you'd have a big effect on that is if you really said we're going to make you uninsured if you don't keep working.

The main way— the evidence is very clear. I agree. Don't just look at a slice. When you look at all of the evidence across the labor force and across entitlement programs, there is one policy that trumps everything else in terms of its impact on having people work longer. And I'll probably a friend— offend some of my progressive friends in what I'm about to say. That policy is not the Medicare age. It is the early eligibility age of 62 in Social Security.

And I think for the long-term we are going to have to raise the 62 age in Social Security. It's hard to do because there are legitimate issues regarding people who have— who do physically back breaking labor. There are some disproportionate racial effects. And in order to raise the 62 age, we have to figure out ways to address those problems. But that is really the way to do it. And if we're going to increase the Medicare age which we may or may not but I think if we do, I certainly hope we're not— we don't raise the Medicare age and repeal the Affordable Care Act and have 65 and 66 year olds hanging out there.

So long as you have another place for them to go even if it's a less efficient way then you're not going to have a big effect on work arrears through the Medicare age policy.

DIANE ROWLAND: We have a clarification question here.

percent cuts take effect? Because if it's January 2013, since the cut will only be effective for nine months of that fiscal year, would the Medicare cut have to be higher than 2-percent to yield a full year cut of 2-percent on average?

BILL HOAGLAND: There my recollection and Bob or Gail correct me on this; my recollection is we went through this with the pay as you go reforms in 2010. And that three months is carried over and there's a way of catching up for that 2-percent. It's a 2-percent—

GAIL WILENSKY: Yes.

BILL HOAGLAND: —on an annualized basis.

GAIL WILENSKY: The other relating to this 2-percent of— and it came up in, I think, a couple of our presentations is that we do need to recognize that— [Interposing]— for healthcare —

DIANE ROWLAND: Somebody else must have— [Interposing]

ED HOWARD: Now you're on. Now you're on. You're okay.

GAIL WILENSKY: For healthcare providers, the 2-percent reduction is likely to be a smaller reduction than what occurs in most other scenarios you could think about. So, while it does not take on the serious issues as— I forgot now whether it was Bill or Bob indicated it would have Medicare—

DIANE ROWLAND: Somebody else there? I don't think this— nothing. Okay.

GAIL WILENSKY: The —

ED HOWARD: You got it.

GAIL WILENSKY: The contribution of Medicare and Medicaid would be substantially smaller. And at the end of the day, we should not be too shocked if we see serious lobbying that recognizes that most healthcare providers are going to be better off with sequestration than with anything else.

BILL HOAGLAND: But let me make clear that if we go to a 2-percent reduction then think about the hit that's going to take place on defense. And I guess my sense at this particular point is then we do have the tradeoff that takes place next year as Bob has talked about with the year 2012 leading up to an election year. A lot of— this is an old timer here speaking, a lot of this reminds me of the fact that 1986 we had a sequester that was to kick into effective. And it had a big hit on defense. And Ronald Reagan was forced into the corner to accept a tax increase verses the hit on defense. There's a lot of similarities here between what this sequester is set up to do.

ED HOWARD: Bob.

BOB GREENSTEIN: Yeah. I would just note that we have

staff; we have the potential for a really momentous lame duck session after the election. Bill and I were talking at the table when we were eating during— when Katherine Hayes was talking, about the fact. I think Bill we thought that the joint committee might well produce something but probably wouldn't get to the full $1.5 trillion. So the most likely scenario is some sequester of whatever size is scheduled.

If that's the case, once we get into December 2012, you've got three things coming at you at the same time. You've got the sequester. And there clearly will be charges that if it takes effect, national security will be jeopardized. I'm not sure. I think that's true. But there will certainly be those charges. Secondly, the Bush tax cuts will all be scheduled to end on December 31st. And thirdly, we're going to hit the debt ceiling again sometime in the early months of 2013.

So, particularly if the joint committee doesn't hit its full target, I think we're going to have another huge round of negotiations, threats of a showdown, big negotiations probably between the presidential election and Christmas in 2012.

BILL HOAGLAND: I can't resist. I just have to make one quick comment. I agree with Bob on everything except for again one small point. [Laughter]. If Congress passes a jobs

frankly, I think we're very close to it as it is. I'm not exactly sure when I put the numbers together because we haven't seen the pay force for the 450 but my guess is the pay for the 450 will come after the expenditures go out or otherwise it's not a stimulus. And therefore, what we're faced with is the possibility of facing a— the staff up here are going to hate this. I think you're facing the possibility of a debt limit increase even before 2012 elections.

BOB GREENSTEIN: Actually something if you look at the way this midsession review numbers, if they're right, then there's not a risk of that and you're into early 2013. But if we go into a double dipper session and the economic forecast in the midsession review and the CBO August forecaster —

DIANE ROWLAND: Mic.

BOB GREENSTEIN: —too opt— if we go into a double dipper session— do I have it on yet? Okay. Let me step back. If the forecasts in the CBO midsession— in the CBO August update and the ONB midsession review are current then even with the jobs package, there wouldn't be any risk of hitting the debt ceiling before 2013. However, those economic forecasts may be too optimistic. And a lot of those economic numbers were done several months ago before the latest data. If we go into a double dipper session then there is the risk that Bill

DIANE ROWLAND: I'm going to just put two questions together since we want to show —

ED HOWARD: That's good. No, you hit it twice I think. Hit it again.

DIANE ROWLAND: Oh. Yes. Okay. So we have two questions that ask of our panel to use a crystal ball and think about what the committee could do. And we've seen they've been using that crystal ball already. One is what the change is of the Joint committee taking up some kind of SGR changes would be and would that be potentially positive thing for them to address? And a second is how that panel might interact with the Independent Payment Advisory Board and whether they predict that it survives or is defunded by the super committee?

GAIL WILENSKY: I don't know what will happen with the estimated $300 billion cost of eliminating the SGR. But I think if there was an ability to seriously redo how physicians are paid; it would have an enormous potential impact for later years spending. But as has been raised is most of the changes that really involve what I would regard as reform are going to take a while to phase in and to show results.

And most of what has been relied on to date is payment reductions in the current dysfunctional environment. And when there are calls for expect yet more, at least that was how I

expected to be one of the contributors to the jobs bill funding, is that this is probably not resulting in a reform in terms of how payments are made and therefore not likely to be very effective. So I am not hopeful that it will actually do much to address the fundamental problem which is getting rid of a system that has physicians billing 8,000 different codes.

BILL HOAGLAND: Just a real quick comment, this— unfortunately this goes back to the baseline. If they assume a baseline that includes the— that— that that it's an extension of current laws as op— extension of the current payment rates as opposed to the reduction, I guess that it wouldn't be a cost then associated with the fact that they would fix it. So it all goes back to that darn baseline and what is assumed in that baseline.

BOB GREENSTEIN: Bill makes a great point about the baseline. And that colors what I'm about to say on this and could make it wrong. My instinct is that the joint committee probably will not do a permanent GSR fix. The Bo Simpson and Gang of Six plans did. But the Obama Boehner negotiations in late July before they fell apart would have done a two to three year SGR fix not a permanent one because they had a harder time coming up with the additional money to pay for it.

So I think that unless the baseline is used in the way

the GSR fix, I think the joint committee will likely take the easy way out and do a fix for maybe a couple of years and kick the can down the road.

With regard to the IPAB, I certainly— in my view, here we have a joint committee that's supposed to deal with deficit reduction. We've been saying on this panel throughout the panel that rising healthcare costs system wide are the single biggest issue for the long-term. Medicare's an important part of that system and is one of the few mechanisms to kind of lead the way.

If we find important payment and healthcare delivery reform innovations, the IPAB is the mechanism— the key mechanism to try to make that happen. It may or may not work but it holds a lot of promise. In my view, it would be a travesty to repeal it as part of the joint committee activities. And if the joint committee did so, in my view that is one of the few things the Joint committee could do that could lead to the potential of a presidential veto of a joint committee report. Otherwise I think something that comes out of the joint committee would be signed.

GAIL WILENSKY: I think we need to stop calling what was included in these various committee or these various reports that postponed the SGR impact by two or three years

leaving the same dysfunctional way we reimburse physicians, rewarding them for doing more and not for doing it better or improving health outcomes. So, whatever else that— it is a serious problem. I understand that. But kicking that can down the road two or three years is not a fix.

ED HOWARD: Okay. We've got a consensus. [Laughter]. Let— we— if I can to our panelists, I'd like to suggest a friendly amendment to what we had used to entice you onto this program. And that is if you could stay in place, you'd probably save yourself a lot of [inaudible] going back and forth. And we'd just ask Chris and Dean to come forward because we want you all to get a chance to [inaudible] on the last Q&A section as well.

And I'm glad that— [Interposing] yes. Could you pass those down for self-placement? If you want to just array yourself at that end— it may be hard to distinguish completely because I think there were a little bit of politics in some of the answers or at least in the predictions that you heard about what might happen. But, we want to focus a little more laser like on the political dimensions of this bundle of issues.

And to help us with that discussion, we have two masters of the trade. Dean Rosen is the partner in head of health practice in public— the public affairs firm of Mehlman,

in almost every committee of jurisdiction and leadership office on the Hill including a stint as the chief health advisor to the aforementioned Bill Frist.

Next to him is Chris Jennings, currently president of Jennings Policy Strategies and head of the Bipartisan Policy Center's State Based Health Reform Implementation Project. And he was the chief health advisor to President Clinton. Gentlemen, thank you for joining us. And we'll ask you to kick off the overtly and almost completely political portion of the program.

DEAN ROSEN: Okay. Great. Well my first challenge is making sure that this can work. I'm so daunted by the last panel. Can you all hear me? Alright, good. Well thank you. Just raise your hand if you can't hear me and this all of the sudden goes off. But I think Bob mastered it after four or five times so now we've all got it done. But thank you all very much for including me. I sort of feel like that old adage after listening to Katherine and then the expert panel that that everything important has been said but not everybody has had a chance to say it.

So I will try to— I'll try to incorporate. It was good to really listen to the first couple of panels because I always learned a lot. And I also, other than the microphones, have to

room and talked to some folks on the way in. Some of the people are going to actually have to make these decisions and do the hard work. And Chris and I have the benefit of observing the politics from the side, so, with apologies to those who are here.

So let me just say I think the fundamental political question which everyone has sort of talked around is you know back to the old game show, Deal or No Deal. And then there's sort of two sub questions for me. Number one sub question; how big of a deal? And number two; who are the political winners and losers if there is a deal? And I'm not sure I can answer the last one but I'll try to.

So let me start— I want to start with a few kind of structural realities and considerations that we've talked about but putting them in a political context of the committee. And then a couple of political observations and then I'll sort of end there.

So the structural observations; number one, as the previous panel said, the super committee really is pretty super when you look at the powers. You know to sum it up simplistically for my simple mind, you know sequestration is old but the committee structure is new. And they do have very, very significant powers in terms of once they come to an

little chance in the way that a number of us who try to influence what Congress does have an opportunity to do it. You can't stall. You can't delay. You can't amend. You can't change. You can't raise objections whether they be budgetary or otherwise. You can't amend. So it's the importance of getting in early. But the Super committee is super.

Number two; and I don't think this has been said exactly but I think one of the reasons that the committee is so unique and so powerful as opposed to some of the past commissions, thinking about the '97 Medicare commission and others that are more recent, is because it's not only a congressional creation but it is a part of the congressional political fabric.

So it gives it the power to act in a way that an outside commission including the one that Bill served on really didn't have the opportunity to put its recommendations into law right away. But what it also means is that it doesn't exist in a vacuum separate from leadership, from committee leadership or from the political considerations of the day.

The third kind of observation I'd make having sort of served in both the House and the Senate and seen some of the processes play out with both Simpson and Gang of Six and others is that I'm struck by how important up here often relationships

that. But the personalities, that third P to me are really, really important. And it struck me the other day. I don't know about others to read that that the two co-chairs Representative Hensarling and Senator Murray in their nine years of overlapping service in Congress had not met until the first meeting of the super committee.

So think about it from that standpoint. You know this isn't like Senator Kennedy and Senator Hatch who had a 20 year relationship and then had a thorny issue to sit down and solve or even the Gang of Six; the Senators who kind of see each other on the floor every day. This is kind of distinctly different in terms of these six members even leaving aside the political and bicameral balance.

And then sort of the final structural observation I'd make is that yesterday we just got over the first day of the football season. Like many of you, I sat in front of the couch for all of 12 hours of football yesterday on national TV. And this is very much like the two minute drill. You know you've got the team together and if you go back to my other point which is related, you know this is kind of like the dream team. You've got a quarterback who's played with a wide receiver but they've got a two minute drill. It's an extraordinary quick time to do a lot of things. And I think that makes it

terms of the implications of what that means. If I count right, from the first official meeting that's supposed to take place this week and I know there was a meeting last week. But the first official meeting until the final product, from concept to final product, it's 10 weeks total— less. To not only have an agreement but to have it drafted, to have it scored by CBO, Joint Tax and others.

So with that sort of structural intro, let me talk about the few kind of political observations and then I'll throw it over to Chris. The first is that I think in some ways and I'll make a partisan political point here for a moment. The fact that we're talking about sequestration and deficit reduction, if I stick with my football analogy, we're kind of playing on the Republican's playing field to begin with which is why I think that in part the President and some of the democratic members of the committee have tried to inject into the process a broader agenda around jobs and job creation. But from a political standpoint, we're really talking about a long held goal of both parties but one where the Republicans, I think, are a bit more comfortable.

Because of the structure that I talked about and structural considerations, the lack of relationships, the tight timeframe, the fact that the committee has to begin so quickly;

article in that— in your packets which is very good and that Bob made which is that the kinds of things that this committee is likely to look at when you think about deal or no deal in the healthcare space are not necessarily things that are going to allow for a lot of creative thinking. They're going to look at Simpson Bowles. They're going to look at the CBO recommendations. They're going to look at the MedPac recommendations. They just simply don't have time when you think about what their task is going to be in terms of having to build the relationships, build the trust, figure out where the agreement is and do the hard work of coming up with the numbers to do a lot of freelancing and come to with a whole lot of creative ideas in 10 weeks from start to finish.

And to make Chris' point, I think what that means is if you look at where Simpson Bowles went or the committee that Bill served on or even was reported from the Biden talks, at least in my simple math and it's— there's a reason I wasn't on the last panel. But you know you're talking about something like at least 3 to 1 healthcare entitlement cuts to the 2-percent sequestration with Medicare and SCHIP off the table. So there is a reason for that.

Make a couple of final political points and I'll stop. One is I would not underestimate. I think a lot of people who

process, you know sort of said well, you know, this committee's bound to fail. The leadership couldn't want this to work. Because you know geez, Republicans if they really went into this and had a deal would have to agree to tinkering with the tax code if not tax increases. And democrats would have to agree to changes in entitlements. But I think there are at least three reasons that if you sort of get out of the healthcare space for a minute that might really compel the committee to act. And I'm not saying that they will act but as we think about the question of deal or no deal.

One is that there is and the polls show this. This tremendous amount of collapse of public confidence in the institutions of Washington that took place according to the polling and according to just my informal feedback from members of Congress who spent August actually talking to real people in public confidence and the economy. And I think that we shouldn't underestimate the feeling that in part there is some political benefit to both sides to accomplish something here. But that I don't know that it quite existed in a vacuum. And I think that that's very, very present and also to provide some economic stability.

The second is that the defense cuts which Bill described in the Reagan era as being something that drove a

really are a bipartisan concern. And Bob indicated earlier they may not be a concern. But if you look at what the defense secretary and the democratic administration has said about the scope and the size of the cuts and you look at the size of the cuts. And you think about even for some liberal members of Congress where sort of the defense cuts are jobs issues, I would not underestimate the ability of the big defense sequestration numbers out there to compel at least a serious look at an agreement.

And then a final point I'd make on that is that one thing I learned in my, you know, decade plus in serving up here is that one thing that a lot of members of Congress don't like to do is give up control. And unless you come in and you rewrite sequestration, you're really in this odd process of saying unless you reach an agreement in 10 weeks; you're going to trigger a 10 year process of automatic cuts that are in effect. And it is a significant amount, I think, of institutional control to lose.

Two last points; one I'm going to answer my first question on big deal or small deal and then deal or no deal. On big deal verses small deal; I think we're going to go through a period of a couple of weeks where the committee is probably going to be urged to take up every issue under the sun

package, infrastructure, comprehensive tax reform and I don't know how it'll turn out. But my guess is that at the end of the day, going back to my structural points because this is a creature of Congress and subject to the politics that it's going to be very, very difficult for 12 members who are so representative, I think, of their caucuses in a process that's relatively transparent to reach a $300 or $400 trillion deal which is probably the size of a deal that we actually need when the president and the speaker in a relatively quiet room with just the two of them couldn’t sell that same kind of deal to their own respective caucuses at the end of the day.

So I'm not sure but I think after a period of examination, we may get to a period of winnowing out. And my guess is and it's just my guess right now that we're going to end if we do have a deal of something that's not of the grand bargain variety. But that's a point.

And then let me just make my last point here in terms of politics. And in some ways I think, you know Chris has set this argument up in terms of healthcare. But I want to leave you with this thought as we— you know most of us here focus, you know, 99-percent of our time on impact of these things on the healthcare programs. And that is while I agree with Chris and his premise in his article that if you just look at the

really is concerned about healthcare cuts, whether it be a provider, an advocate for these programs or a consumer, you just look at what's likely to happen. You know three or four times as much cuts as the sequestration process. There's no question on a numerical basis, you're "better off" if you look at it from a short-term basis.

But I firmly believe and I say this to friends and clients and colleagues alike that if you believe that this is going to be the beginning and the end of healthcare reform, I think you are mistaken. I think whether or not the committee comes up with an agreement with $300 - $400 billion in healthcare cuts or not, it's not going to get to for the political reasons that Gail and others described the grand bargain in terms of restructuring these programs that are needed.

And I think that whether there's sequestration or not, whether there's an agreement or not, I think we're at the beginning of a number of years of significant deficit reduction. You really just can't get there without taking a much more hard look at Medicare, at Medicaid. Yes, and the Affordable Care Act which I think will largely be off the table in the short-term and other things. So I'll conclude with that. Thanks.

CHRIS JENNINGS: I know— can you hear me? Yes? No? Yes. Thank you. Well I'm finding myself shocked. I agree with almost everything Dean said. [Laughter].

DEAN ROSEN: You're going to ruin my reputation.

CHRIS JENNINGS: Let me just say that first of all I was listening to the first panel. No, not— Katherine, you were great by the way. Thank you. [Laughter]. But the second panel and I was thinking and many of you are too young but not all of you. There's a very famous comedian named Steve Martin— [laughter] who— [laughter] who said that you know he— in part of his act, he plays the banjo. And he's you know there's a great thing about the banjo. You can't play a depressing song on a banjo. [Laughter]. But I think this panel could. [Laughter].

On the aftermath of the anniversary of 9-11 and I'm just looking here at the capital. And I just want to say that I do believe that big and bold things are possible. And I think that they should happen. And I, even in my article, I said that. I said specifically the better policy is a big, balanced deal. And I'm hoping that we can get there.

I think the politics of this are going to be quite hard. And I have to say that and I'm going to talk a little bit today about why if you’re a healthcare stakeholder, you

the country, for the economy, for job growth; a big balanced deal would be best. And I'm secretly rooting for something like that although a little bit cynical.

Now people like us and people like you have been around long enough to know that when people in Washington predict little to nothing will happen and get paid for it, that's not really a big deal. The big issue really is to find those moments in time that when something is poss— where people come to the table. I think at the end of Dean's remarks where he said there is the possibility in the aftermath of the August recess where the public really is so tired of the finger pointing and the lack of collaboration in the last progress that both sides, one could argue, have a political as well as policy argument to come together.

Having said that, I think all— for all the reasons that you've heard today about how difficult it is to even agree on a baseline let alone a policy, you know, partnership that is very balanced, etc. I think it's going to be a tough, tough road to hoe. And I think it's fair to say— I'm sorry, I'm going to turn off my wife I think. Sorry. And I have to say that though that this can not be a one sided deal. It's just that— it's just that simple. And if one is going to put very, very difficult issues on the table like entitlement reforms and I

might even be counterproductive to the longer term objections of the delivery reforms that we all know we're going to have to get to eventually. Then there really has to be a recognition that there has to be revenues on the table too.

I mean it's just— you know it's so obvious. And everyone recognizes this but it bears saying over and over and over again because in the absence of that, we're going to have, I think, sort of a gamesmanship but not any progress.

Now I— let me just go really quickly to the stakeholders and I'll come back. I do think that there are exceptions probably to to my overall analysis of why almost all healthcare stakeholders would prefer the sequester. And again, that's— they would prefer the sequester to a bad deal. This is what Bob was saying. Bob was not saying and nor am I that the sequester is a good deal. We're saying a balanced approach is a good deal.

But in the absence of that, an intermediate hodge podge pick cuts and hurt people and shift costs and undermine the healthcare delivery system makes no sense period. Not— I mean forget the politics of it, just from a good policy perspective. Now the hope is that we can get over that. But in the interim until it can be proven that a balanced approach can be taken then look if you're a consumer group, you've already been

exempted from any cost sharing. You've been exempted from Medicare programs.

If you care about poor people which most of us do, Republican and Democrat alike, than why would you open the door to Medicaid cuts when you know today we already are getting savings at the federal level as results of states cutting? We're already using the states to cut the federal Medicaid program. Right? We're already sharing in those cuts. And they have no money. So now we're going to cut more and shift more burdens to the states. Does that make sense?

And if you're a business and you're looking at the numbers that Bob talked about where the private sector growth rate is already above the public sector growth rate and you cut more on the public side. What do you think they're going to think about this? They're going to think about this as being cost shifting. Cost shifting right back to them.

And if you're a hospital after you've just gone through $150 billion in cuts with Affordable Care Act. Or if you're a home healthcare and you know you're designated because your growth rates are going way, way high, do you want to be applied to a cut that far exceeds $140 billion over 10 which is likely to be $300 - $400 billion and you know that you have both Medicare and Medicaid? And if you're pharma, oh my God, if

applied to you. But guess what, it's almost inevitable if you have that big number.

So you know it's not— it's— stake— you know the stakeholders, you know in Washington we say you're a stakeholder if we like you and a special interest if we don't. [Laughter] So I don't know what we are or any of those folks are. But in the end of the day, they represent their interest. But they fundamentally believe that there will be a deal. And I predict that it will be after a lot of effort to do the bigger deal. And I hope the bigger deal works. And I'll work and contribute to it to the extent that it can.

But if it can't then it should not be on the backs of poor people and it shouldn't be back on the backs of the healthcare's community when we're still trying to implement the Affordable Care Act. It really makes no sense. So do— the prediction would be in an effort towards large, probably movement towards the sequester with the biggest danger actually being something in between. An intermediate size cut that could be very, very flawed policy which may fall together at the very end to a sequester or partial sequester. And then we move on to the election in 2013.

Now lastly, I do want to say this. I mentioned there are two exceptions to this rule. If you're the physicians, you

you have to find another vehicle if they don't to fix your problem. And if you're a— and if you're some health plans, particularly if you rely on Medicare a lot, many of them will suggest that they'd rather go and work with the super committee. But the balance of the stakeholder community will conclude as I did, I think, that in the absence of a balanced deal, we're going to have to hope for a sequester. With that, I'll conclude.

ED HOWARD: Okay. We have— am I on? Yeah, I guess I am. We have another opportunity to let you interact with not only the panelists you have just heard but the ones you previously battered with your questions. Once again, use the green cards or a piece of paper or anything else if you want to write a question. And the microphones are there for your use.

Let me just ask a quick clarifying question to Dean Rosen if I can get his attention for a moment. Strictly sort of process oriented, you said that you expected this super committee process to be relatively transparent. And I wonder if you could expand on it. Is there any reason it should be any more transparent than say an executive session of the Ways & Means Committee?

DEAN ROSEN: Well I was— my expansion on it would just be that I think that the process that was, for example, led

certain points was the Speaker and the President was a lot harder room to get into relative to, you know, 12 members of Congress who are going to hold some public hearings and put up a web site.

But I mean, you know, it probably will be very much like a committee in the sense that they'll have some public hearings and they'll listen to people. And they'll meet with stakeholders. But at the end of the day, if they're going to get things done, as I think the chairmen both acknowledged, they're going to have to close the door and figure out where they stand on some of these issues as well. And I expect that that will take place as well.

And I just make the point that I think it even though they do have these powers, I think it makes it more difficult to— I think it makes it in some ways a little bit difficult for them to just shut the door as like the President and the Speaker could do. Or the Speaker and the Leader could do and say, you know, let's go do this deal. And that was my point.

DIANE ROWLAND: One of the earlier questions we got was what are the implications of the super committee for sustaining the Affordable Care Act? And Chris, you just referenced that. What do you think the interaction there might be? Since we've already talked about how they have open rules of what they can

CHRIS JENNINGS: Well, you know, I think every issue related to the budge and deficit and debt and reforming the healthcare delivery system in particularly has to focus on the impact this has on the implementation of the Affordable Care Act at the state level much more so than the, you know, federal level. They are hurting on the revenue side and they're hurting on the growth side. And, if we squeeze harder, we'll just only make it more challenging.

I don't know if the members of the super committee are contemplating all those issues right now. I suspect they're not. They have other problems. But, you know, this is why, you know, although we've— this is again why the sequester becomes a little bit important here because it does exempt the Medicaid program at a time that's very, very difficult for these states.

And you know for the health plans who desperately want the states to implement state by state exchange; they don't want a federal fallback. It's not really in their interest either. So, this is why I think as people step back a little bit more and more about this, they'll hesitate about having big cuts on the Medicaid side. My hope is the administration lowers its threshold too on the Medicaid side because in the long run it's going to undermine their own objectives.

DEAN ROSEN: Can I just make one political point about the Affordable Care Act which is I think we— you know we've heard a lot of discussion and I think a lot of the popular press likes to focus on the fact that, you know, Republicans have, you know, taken off the table tax reform as part of the— as part of the deliberations of the super committee or other things. I don't think that's completely true. I think that it's unlikely that we'll end up with, you know, significant increases in the marginal rates. But I think that even some of the comments of the most conservative members of the super committee indicated that they'd be open to looking at things like ethanol subsidies and other tax revenue.

But I think also politically and Chris' comment I think sort of underscored this in a way even though he didn't say it directly. You know I think as the super committee deliberates, it's also important to recognize that, you know, some $2 trillion in new subsidies are sort of politically off the table and that I don't see, you know, leaving aside maybe some pieces of the public health fund and some other things that might be nibbled at around the margins and leaving aside the Medicaid issues. I don't see this committee being able politically nor was it part of the Biden discussions or other discussions to really significantly look at some of the significant subsidies

Act. And that's pretty much off the table too unless I'm wrong. I just don't see that coming through a political process. So I make that point as a political point to it. In some ways, if you argue that some Republicans have taken taxes off the table, I think you can argue that most Democrats have also taken the Affordable Care Act off the table as well.

BOB GREENSTEIN: Well I'm sorry. I just have to say one thing. The Republicans have not taken off the healthcare reform legislation off the table. They want the savings. They just don't want the investments for coverage expansions. So, when we ever— if we had a dream scenario where everyone took over Republican White House, Republican House, Senate and we had the Michelle Bauchmann repeal legislation, it would not include all the cuts in Medicare and Medicaid period. The Ryan bill didn't. Hers won't, etc.

So the real dynamic here is; are we going to have a sustainable healthcare delivery system that works for all Americans or not?

ED HOWARD: Let me just clarify. What you're saying is that Democrats and Republicans seem to agree there should be these cuts in the healthcare programs. The Democrats would spend it on coverage subsidies. The Republicans would use it for deficit reductions. Is that fair?

DEAN ROSEN: And tax cuts. Well actually the Democrats would preserve the law. And Republicans would repeal the law except for the cuts. Yes.

ED HOWARD: Okay.

DEAN ROSEN: Yes. That's one— [Interposing]

ED HOWARD: Yep. Yeah. You could probably get a partial consensus on that. Yes, go ahead.

TONY HAUSNER: Hi. Tony Hausner again. I'd like to ask each of the panelists what you would recommend in the way of changes in the healthcare system that this committee should consider. And what would you recommend— what do you think is likely to come out of the committee in terms of changes in healthcare policy?

ED HOWARD: And I should say Dean and Chris should take first crack at this if they want to but I would encourage the other panelists to chime in as well.

CHRIS JENNINGS: I'll take a first crack without being exhaustive. I would just say I think that I would say that in general, I agree with Gail that we need to look more seriously at structure reform of all the programs to try to make them more of a competitive pair in and to reward value. And I don't hold out much hope that that's going to happen or that something that would be as significant as something like the

But one thing I would say is that even in the Ryan plan, you would still have the Medicare fee for service system existing for a long time. It would exist for everybody under 55 and then it would be grandfathered so everyone could presumably choose it even after that point. And I think that there are a number of things that I would say are not provider cuts but that would be structural changes to the benefit package design and even the way that we pay in terms of the fee for service system that I think are right for this committee to look at.

And in fact, if you look at the sources that I mentioned earlier, the Bo Simpson, the Biden talks and others; those kinds of changes to coinsurance, those kinds of changes to reward quality were really part of the discussion. I think those are the kinds of things that should be considered even absent sort of full reform of the programs.

DEAN ROSEN: The— our list of cuts? I mean I think that, you know, the irony of course about repealing some of the legislation here and I'm only— I'm not saying this just because when we talk about delivery of forms, you know, many were talking about ACOs, CERs, CMMI and the Innovation Center. You know? And you know you— now people are talking about wanting to repeal those legislations. The very, very, very policies

we need to do. Let me say though that to the extent that we can move aggressively in those areas, we should. Absolutely because fundamentally there are approaches that won't end up shifting costs, they'll end up constraining costs and having the potential to be transplanted in both the private and public sector which is really what we're trying to do here. So I agree with that.

On the cost sharing and this is what we're talking about. When we talk about delivery reforms we're talking about cost sharing for beneficiaries. And I think that, you know, moving in those directions makes some sense if they're thoughtfully constructed. In other words, we're— we need to approach cost sharing as a way not to avoid the over or under utilizations. We need to move towards cost sharing to get to appropriate utilization of healthcare. And in some cases, that means having no cost sharing. And sometimes that means a lot more cost sharing. That's really what we need to get to a carefully designed approach.

And I think you're already seeing some discussions about that both potentially with members of the super committee but also Senator Warner and other people have talked about thoughtful ways to move in this area. You know it's all— everything should be on the table but again in a balanced way.

BILL HOAGLAND: I'm a budgeter so I have my list. I'll just give them to you right down the list here. I think MediGap has to be on the table. I think reform of TriCare has to be on the table despite what's been said by my friends at the other end of the table. I think we ought to look at the up— the subsidies up to 400-percent of poverty that are in the Patient Protection and Affordable Care Act.

I would also say that the hardest problem I always had up here and I think the healthcare people have is scorable savings. And so I would suggest that maybe one thing this committee could look at is having a specific scorable CBO score, a reduction in hospital payments, if you like reimbursement rates. But tie that to that does not happen if there is a reduction in readmission rates as an example. Some way to get the incentives which they will not score built into this. And probably I shouldn't say this as a representative from CIGNA but I do believe that on the tax side I think the committee will probably have to look at, if they get into the tax code, the employer sponsored exclusion for health insurance.

DIANE ROWLAND: Gail.

GAIL WILENSKY: I agree with most or all of what Bill has just suggested especially the issue of the employer

is a possibility of getting to a broader, not the big deal kind of concept but a more significant package, we will look at it in terms of increased revenues primarily focusing on increasing the tax waste and not what has been, in my mind, an almost exclusionary focus on increasing the rates on what is already a narrow base.

Many of the incentive issues, not that there won't be incentive issues involved in increasing the base, there will be. But they can be frequently much better justified in my mind than just looking at what has been seemingly like a singular focus on increasing the rates. And I would certainly put employer sponsored insurance at the top of that list because it's a huge amount of money.

I don't know whether it's possible to do this. I am very concerned about when we will get around to looking seriously at entitlement reform. I think it is very unlikely in the 10 week frame that can happen because they're very difficult issues and because there's of the fundamental divisions, you know, that I mentioned earlier in terms of how people look at this.

I would like to see something like the super committee be established after the election with a somewhat more reasonable timeframe to come up with the issues about how

the long-term care or the non-acute care part of Medicaid which is the more problematic part of Medicaid in my mind where the— we desperately need to change the incentives so that you can have a reason to not move people ping ponging back and forth between nursing homes and hospitals, etc.

But I don't see it happening in the very short window. And we need to find a way to light a fire and I think we need more of a consensus view on what it means to reform Medicare. I think we do not have in the Congress anything like a consensus about what a reformed Medicare world would look like.

ED HOWARD: Bob.

BOB GREENSTEIN: I'm going to largely agree although not entirely with Bill's list. But I would start with a framework which I alluded to earlier. I'd like to see a framework in the joint committee. For every dollar one side agrees to in cuts in mandatory programs, the other side has to agree to a dollar in revenues. For every dollar in revenues, there has to be a dollar in mandatory program savings.

It's a little difficult to talk about asking Medicare beneficiaries of modest means to pay more in cost sharing while saying that we can't discuss things like asking multimillion dollar hedge fund traders to pay a normal rate of tax rather than pretend that their own investments are being made and that

tax rate through the carried interest loophole. You've really got to look at all of these things together.

That being said, I agree with Bill that the MediGap area particularly the first all wrap around coverage is something to look at. We may be able to improve incentives there that produce some Medicare savings due to changes in utilization. I think there are some things to look at in the cost sharing front that people have talked about for some time where maybe there's a tradeoff of some modestly higher cost sharing on the front end coupled with better protection than Medicare now provides for catastrophic costs on the back end.

We, of course, in all these things have to be particularly careful about lower income people that we don't end up in a situation where people forego needed care because they can't afford it. But there ought to be some reforms in that area that can yield some savings. I know it won't pass but I really am very attracted to the idea of securing for people that get the Medicare low income drug subsidy for that population the type of pharmaceutical rebates that the Medicaid program got before 2003.

I also think there's a larger lesson here. In 2003, the argument was that the private competition would produce such savings that we'd get better prices than Medicaid paid and

to be the case. CBO estimates $112 billion in saving from that reform.

As I noted earlier, there are some saving to be had from counting Social Security as part of income for Medicare–Medicaid and the new subsidies in the health insurance exchanges under the Affordable Care Act. There's some smaller changes. I think they're largely in the President's February budget in things like durable medical equipment. In other areas I think Bill had another good suggestion in looking at TriCare. And I also agree with Bill and Gail that, again, this isn't going to happen in the joint committee either. But really in the long run I would shift the excise tax on high cost plans in the Affordable Care Act to a well designed cap on the exclusion for employer based insurance.

The one area where I'd strongly disagree with Bill is that if we're going to have a mandate that people must buy coverage then the subsidies for people up to 400 in the new exchanges are actually right at the edge of whether they're enough to really go with the mandate. And they erode starting in the second decade when they're only adjusted by the CPI and not by healthcare costs. And I sure as hell wouldn't lower them one dollar. I think that's really dangerous if you really want to have a mandate that the public can accept and live

DIANE ROWLAND: Okay. We had one person at the mic who gave up on us. Do you want to come up and ask your question quickly? And then Ed's going to put in an evaluation [inaudible].

SARAH KLIFF: I didn't want to keep anyone too late. Sarah Kliff with the Washington Post. Thank you guys for doing this. I just had a quick follow up on one proposal that got a little bit of discussion earlier raising the Medicare eligibility age to 67. Was curious where you see kind of health industry interests showing where they fall in that. I saw that the Hospitals' Association supports it. I was just curious, you know, what the business, you know, interest is in seeing that go forward or not go forward.

CHRIS JENNINGS: Well, you can hear me, right?

SARAH KLIFF: Yes.

CHRIS JENNINGS: You know for the most part a number of providers are worried that if we engage in this bigger discussion that there'll be beneficiary saving on the table as well to moderate the total number of saving for providers. So there is a little bit of dynamic there. From a perspective of the hospitals, of course, you get a higher reimbursement rate from the private sector. So if you believe that that population will have health insurance, you know it makes some

The concern that you'll hear from in the stakeholder community will be the business community who will feel that it's a straight cost shift to them. They hate COBRA. They'll hate this even more. And I think you'll see other people as well. So for example the states will feel in the midst of everything else you're doing to me, you're going to add another population of people that I have to cover, lower income population, the Medicaid program.

So, I suspect those will be the two biggest push backs. The providers not so much. The consumers, I think they are people who can be counted on to be very, very concerned. And then it's sort of jump— now I will say and I think Bob and Gail did talk about this. The only reason why this is even possible to have a thoughtful conversation and debate over this is because of the existence of the Affordable Care Act. In its absence, with the subsidies, it makes absolutely no sense whatsoever.

BILL HOAGLAND: Can I— I was going to—?

ED HOWARD: Go ahead, Bill.

BILL HOAGLAND: I just want to make— I was going to— I'm glad you stopped on that point because I think the business community, Chris, is a little divided on this particularly for those companies with early retirees. Some of them would be

them but some would be happy to take their early retirees and take them off of their books and put them onto the exchange. My problem with this is, of course, then it doesn't do anything as it relates to the federal spending.

CHRIS JENNINGS: Yeah.

BILL HOAGLAND: So, I think it's a— [Interposing]

CHRIS JENNINGS: Bill, I just— I would just say look at the retiree health trends and look how small the numbers are. It largely most people in our community would see it as a net loss. But I do agree, for those few that have some retiree health liability that might be something worth considering.

BOB GREENSTEIN: That was— maybe I don't understand this. It was my understanding there'd be some employers for whom if there isn't Medicare; their costs go up because the employer based coverage becomes the primary coverage. The other thing; this is a larger theme, is one really needs to look at the interacting effects of various proposals.

ED HOWARD: Yes.

DIANE ROWLAND: Yes.

BOB GREENSTEIN: For example, let's suppose one going to a blended rate in Medicaid. Then if you raise the Medicare age to 67, under all the proposals to do that, it's coupled with a modification in the Affordable Care Act under which the

the poverty line goes to the 67th birthday instead of the 65th. So then the 65 and 66 year olds, states would have to pay on average somewhere in the vicinity of 40-percent of the costs.

Now for people that deal with governors for 20 years, they've been pleading with the federal government to take more of the healthcare costs of seniors off their backs. This goes in the other direction. And if you kind of say to states we're no longer going to allow you to make full or even any, depending on the proposal, use of provider taxes to help pay for Medicaid and we're going to cut you through the blended rate and by the way, we're also going to put the 65 and 66 year olds who were between the current Medicaid income limit and one and a third times the poverty line on your rolls as well. And you're going to have to pay— I mean you add that all up. I think we would see a bipartisan revolt from the governors if you did all of those things at the same time.

So because of the way that particularly for duals, Medicare and Medicaid interact. One's going to have to look at any given Medicare and any given Medicaid proposal together to see what is the overall interactive effects of all the Medicare and Medicaid proposals that are being considered.

GAIL WILENSKY: The med— the dual eligibles are important. Like we, when we're thinking about the— when we're

and the increase in the longevity, I think we have to be careful about not tying broad overall fiscal and employment policy as it concerns seniors with the relatively small but expensive population of dual eligibles. I agree that they are a concern. And Bob mentioned before or Chris that making sure when we look at some of these changes in policies, we protect or make some kind of modifications for the poorest in our population.

But that does not strike me as a very good rationale for not reconsidering through a combination of tax changes and other changes our expectations regarding at what point people are in retirement. And we— I mean we have a world given longevity where you have people who are going to be retired a substantial proportion similar to the time they spent in the labor force. And it's still longer in the labor force but it— the part that they're going to retired is creeping up to be, for many individuals, half of the time or more that they were actually in the labor force.

There are very few public support plans that have been designed to support that kind of longevity. So I think we— the dual eligibles are important but I don't want to look at all we do with regard to retirement labor force policy on the basis of the dual eligibles.

ED HOWARD: Okay. I think we've come to the end of our time. Diane, I think you had a couple of remarks to make.

DIANE ROWLAND: I just wanted to say that I think the super committee is going to have to be a miracle worker to be able to balance all of the interests that we've talked about today in the timeframe that's been given. But I also think today's session clearly shows us that there's a lot more we could continue to talk about. And I think it's a good billing for the follow-up sessions that Ed is planning that looks more specifically at Medicare and Medicaid.

But I wanted to also go back to the real early comment that Bill made about we can't also forget the effects of some of this deal on the rest of the non-mandatory spending programs and a lot of healthcare policy is embodied in the appropriated programs. And we ought to keep those on the table as something we look at as well.

ED HOWARD: Excellent. Thank you for hanging in there for a very long program but one that I found lively and productive and informative all the way to the end. We'll see on the screens a reiteration of our plea that you complete the evaluation form; help us make these programs better. If you haven't filled it out already and you're still fussing with it, tell us how you like this format as opposed to our regular one.

And, thanks to the Kaiser Family Foundation and our other sponsors, the SCAN Foundation, Robert Wood Johnson and The Commonwealth Fund for diving in and allowing us to do this series on very short notice. And finally I ask you to join me in thanking our panel including Katherine Hayes who didn't come up again for a very great discussion. [Applause]. Thanks very much.

[END RECORDING]