ALLIANCE FOR HEALTH REFORM

# Healthier and Wealthier, or Sicker and Poorer? Prospects for Medicare Beneficiaries Now and in the Future
# The Kaiser Family Foundation
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ED HOWARD: Good afternoon. My name is Ed Howard, I am with the Alliance for Health Reform and I want to welcome you on behalf of Senator Blunt, Senator Rockefeller, and our Board of Directors, to this briefing on exactly who is on Medicare now and in the future. What their health and financial situations are and will be. So we are very pleased to have you with us in what we hope is going to be a timely and useful discussion.

Now, Medicare is the largest healthcare program certainly at the federal level. It covers what? 50 million people at the total cost of about 600 billion dollars. It's about one out of every six dollars that the federal government spends. So no one should be surprised when members of Congress take a sort of Willie Sutton view of Medicare during the discussions of the federal budget and how to get it under control. So while it is true that healthcare spending generally and Medicare spending in particular have slowed their rate of increase in the last few years and while its also true that most analysts predict that Congress won't be pursuing a grand budget bargain any time soon that might propose major changes in Medicare, we still thought it useful to offer a brush-up course for Hill staff and others about current and future demographics of Medicare beneficiaries and how they might be affected by some of the more common proposals for change. Which, if they are not acted on or considered actively in the next couple of weeks, may be just over the horizon. Our partner and co-sponsor of this briefing, the Kaiser Family Foundation, turns out some of the best, maybe the best and most understandable analysis of Medicare you are going to find. And you can see if you agree with me after you look at several Foundation publications included in your packets and you are going to hear from Tricia Neuman from the Foundation in just a moment. In fact, that moment has arrived. Tricia, thank you for joining us and we look forward to your comments.

TRICIA NEUMAN: Thank you, Ed and thank you panelists for coming today. Thanks everybody in the room for coming on this spring-like January day. And thanks to all the terrific staff at the Alliance for putting together this important briefing and all the materials in a relatively short order. So on behalf of the Kaiser Family Foundation, I want to thank all of you for being here.

We are very pleased to be here to talk about Medicare. And we are pleased that so many of you are here because it would appear that Medicare is not a front burner issue in Congress right now. But I think the fact that you are here indicates that you realize as we do that Medicare is never far from the horizon in these halls and that is not only because Medicare is a budget issue and budget issues seem to dominate from year to year. But also because Medicare is so important to the more than 50 million people who are on the program, as Ed just mentioned. So we did think it was a good time to talk about what does the population look like today and what will the population look like tomorrow? I'm going to provide just a few background slides and then turn it over to our incredibly capable experts who are going to give you a lay of the land.
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Many of you know this, but I think it's important to point out that while many beneficiaries enjoy relatively good health, many have modest resources, income savings and home equity, as you are going to hear Gretchen Jacobson talk about in a little bit. And many have significant health needs, which obviously makes Medicare so important to them. So just to go through a few of these, a third of all people on Medicare have one or more functional impairments that limit their ability to do things like walk, eat, transfer. Almost a third have a cognitive impairment. Many have chronic conditions, in fact 30% have four or more chronic conditions and many are in fair or poor health. My point is, this is a population that has significant needs and relies heavily on Medicare. So Medicare covers many of the benefits that people require for their healthcare services, but it has high – several deductibles, including a hospital deductible which is more than a thousand dollars, a part B for physician services deductible and a part D deductibles. And various co-insurances that vary by services. So people don't exactly have a free ride.

As you can see from this exhibit, we have been doing some work looking at what people are paying and even though people have Medicare and many have supplemental insurance, older households, Medicare households, spend substantially more for healthcare if you take into account premiums and other expenses, then younger households. Now that may not surprise you but just remember that these folks also do have other expenses. Just because you go on Medicare doesn't mean you are not paying your rent, you don't need groceries, you don't have transportation expenses. So it is a larger share of a small budget.

We said earlier that Medicare is going to be on the agenda, no doubt, because Medicare itself faces challenges. We have talked about Medicare being about 16% of the federal budget, so Medicare is a rising share of the budget and the economy, so whenever there is an interest in constraining the growth in Medicare spending or federal spending, Medicare is on the table. Medicare also faces long term financing challenges and that is a separate issue which brings about separate policy options, which I think our panelists will talk about. And as we mentioned, beneficiaries face challenges and that is a challenge for Medicare. Many have high out of pocket expenses, Medicare doesn't cover long term care, Medicare doesn't cover dental services. And the Medicare benefit structure is fairly complicated with various co-insurance requirements and A, B, D, the various parts of Medicare that we are not going to get into today. And there are other challenges including improving care management under the traditional Medicare program and under managed care plans and improving the interventions that are available to people to manage chronically ill patients. Other challenges are setting fair payments to providers and plans and that is something that you must hear about all the time from the various doctors, hospitals and other healthcare providers in your member's districts. And speaking of which, there is this little issue called the sustainable growth rate or Medicare payments to physicians, which comes up fairly frequently, because the formula has led to threatened reductions in payments to doctors and Congress has had to step up to do something about that.

So the question on the table is what will be done and when will it be done? As you can see here and as mentioned, Medicare has had a fairly good track record in the past several years. Medicare spending has been growing slower than projected. As you can see in this next slide, Medicare is actually projected to grow slower than private insurance on a per person basis and that may surprise you, but that is actually what the projections tell us. So this raises big questions that our panelists are going to talk about. Can Medicare continue to grow this relatively slow rate per person without having adverse affects? Will there be pressure to increase spending? If not, what will the impact be on access to services, out of pocket spending and the providers who are serving people in Medicare.

We can expect that there will be a number of proposals that come up in the future, it's hard to know when, but they have certainly come up in the past and because this particular panel is focused on the people who are covered by the program, I just wanted to tee up some of the proposals that have significant potential implications for beneficiaries that you will be hearing about. In the context of proposals to achieve savings, there are options to raise premiums for everyone or people with higher incomes. Introduce new health co-payments for every new enrollees. Raise deductibles. Discourage Medigap supplemental insurance. Restructure the whole Medicare benefit design to simplify it. Raise the age of availability and something called "premium support" which is an idea of transforming the way the program is financed and administered. There is also some discussions of benefit improvements, but benefit improvements tend to come at a cost, so they are more difficult to move through the process in an environment where there is so much focus on future financing of the program and deficit and debt reduction.

So with that set up, I think we are going to turn it over to Dan Perry, who is going to tell us what the future of the Medicare program may look like and what their needs might be.

ED HOWARD: Dan, if I can ask you to forebear for just a minute, let me do a little housekeeping if I can. You have materials in your package that include a lot more biographical information about our speakers that we are going to be able to provide you orally. There will be a webcast thanks to our colleagues at the Kaiser Family Foundation; it will be up either later today or tomorrow on KFF.org. You will be able to reach it through the Alliance's website at allhealth.org, where you can also find a transcript of the briefing within the next couple of days. There are question cards you can use when we get to the Q & A sections. There are also microphones you can use to ask your question in person. And a blue evaluation form that we hope you will fill out to help us make these programs even better. Forgive me, I have forgotten the hashtag if you are a tweeter. It is #Medicarefuture. Thank you for restoring the title slide for me to see it. And now, the aforementioned Dan Perry. He is the founder and president of the non-profit Alliance for Aging Research and as he pointed out, we alliance people have to stick together. So we are very pleased to have you with us, Dan.

DAN PERRY: Thank you very much, Ed and hello to all of you. I am going to engage in a little scene setting, going back a ways and taking the 30,000 foot view of just what we are talking about with this unprecedented demographic phenomenon – the aging of our population. And while we are talking here today about the US, indeed we are talking about a phenomenon that spans the globe.

At the risk of stating the obvious, the human experience of growing older has undergone quite a change in the last 50 years. When this image was made, old age was venerated; long life and old age were considered a gift from God and a reward for a virtuous life. It was portrayed as nearly an impossible goal, because very few people made it this far. Let's fast forward 150 years, America is stepping boldly into the post World War II world full of optimism and can-do confidence, but as this very popular book cover suggests, the view of longevity still left something to be desired. And in fact, reading this is quite a hoot. The message is, okay, you are 40, you are obviously surplus goods at work and at home, but with the power of positive thinking, you just might be able to eek out another ten years or so. Well, nowadays the sky is the limit and advertisers and senior citizen organizations are saying we can have it all and we can have it all now. It's all good. Well, what is driving and what is behind this new vision of old age? Well, of course it's the maturing of the Baby Boom generation. Our largest generation in history. And here is Kathy Casey Kirschling, born just a few minutes after midnight December 31st 1946 and then obviously the first to turn 65, which was in 2011. And in 2011, our population went from producing about 6,000 new 65 year olds every day and it had been like for decades. But beginning in 2011, we went from 6,000 a day to 10,000 a day and it will stay at 10,000 a day for the next 15 years. That is the size and dimensions of the aging Baby Boom generation.

So now, even state old life insurance companies like Prudential are seeing that there is some commercial gold in this aging Baby Boom generation, so you see projections like this on billboards and not to be outdone, National Geographic, not exactly a supermarket tabloid, is telling us in various of images of populations around the world, that 120 is not beyond reach.

So since we are talking today about healthcare costs and Medicare, perhaps the best way to view the trend lines in the US is to track the population of people aged 85 and over. Because that is the age, approximately, when geriatric health challenges really become dominant. And that little 0.1, that is about 100,000 people in the entire US over the age of 85 at the beginning of the 20th Century – not quite enough to fill a couple of blocks in Condo Canyon in Miami. But you can see how its grown and when you get into the red, that is about where we are now and you can see that we are headed toward close to 20 million Americans over the age of 85 by the middle of this century. And we all know, as much was we love the idea of long life, with longevity, at our present level of scientific knowledge and medical knowledge, we face increasing risks of chronic age related diseases. Cancer, hypertension, type II diabetes, vision loss, bone and joint ailments and the worst in terms of cost and perhaps the worst in terms of impact on our lives and those

of our families, the neurological degenerative diseases like Alzheimer's and Parkinson's disease. Unless we are able to moderate the rising risk factors of these age associated diseases, we can simply multiply the very astounding numbers that we now face in terms of risk and costs of care from what we call "the coming silver tsunami" of chronic age related diseases and infirmities. The print is pretty small, I don't know if you can see these, but the major age related diseases are cardio vascular disease, cancer, diabetes and the one all the way to your right, screening up to about 200 million people affected today, is Alzheimer' s disease. And because I'm an advocate for more medical research to get ahead of this curve, I point out to you that that tiny little blue bar at the bottom is what we are currently spending on medical research to slow or to prevent these diseases, and that is part of the problem.

This graph shows us where the vast majority of costs are currently going in the Medicare budget. This reflects a little bit of what you saw from Trish. It should be no surprise that Medicare program for healthcare for the elderly and disabled, spends most of his money on the sickest beneficiaries. So fully half of the people on Medicare are relatively healthy and stable. They are costing only about five percent of total healthcare spending and that is the little slender bar to your left running from healthy to stable. About 23 million beneficiaries or about half of the total. Then the middle part, as you can see the chronic diseases start to set in and as that graph starts to get higher toward multiple chronic diseases, the costs go up. But even at that dotted line, we are talking about 85% of the Medicare eligible population and they are accounting for only 25% of the total funding. So if Ed raised Willie Sutton as where you go to find where the problem is or where the opportunities are, it is obviously in that 15% of Medicare beneficiaries that are dealing with three or more chronic age-related diseases. And if we can make significant savings in Medicare, it is going to take place in this group with four, five, seven chronic diseases at the same time. Fifteen or more prescription drugs at the same time. Mobility issue, care giving issues, this is where our target ought to be for modifying policies. Those that have studied this geriatric patient population can agree on some of the major objectives that good care can produce and it's all about prevention, care coordination, Medicare management, better coaching by healthcare professionals and as we move through that list, people with chronic diseases, we really need to have better validated measures of quality of life. What can they live with? How are they getting along? So this, I offer to you in very short outline, is the toolbox for increasing healthy aging across the Medicare population and if we do it right with prevention and research, we will get at that 15% that are the multiply chronically disabled.

In short, we ought to be aiming for what this publication from the Institute of Medicine proclaims some years ago. And that is to aim for, in the second 50 years of life, health promotion and disease prevention, again, based upon achievable objectives for prevention and care coordination. And what is at stake in all of this is nothing less than an aspiration for healthy and independent living for all. Because the blessings and the benefits that come from this again major age related diseases, will elevate the lives of all of us and all of our families and indeed the nation as a whole.

And with that, I will close with this wonderful quote from Robert Hormats. He is the Under Secretary of State for Economic Affairs and a former Vice Chairman of Goldman Sachs. Not exactly a guy with his head in the clouds. But he said that "the nations that learn to tap the productive potential of their aging populations will be the ones that dominate the 21st century – economically, socially and politically." So lets keep that in mind through the rest of today's discussion. Thank you very much.

ED HOWARD: Gretchen, let me not give you the introduction that you deserve, but the one that we have time for, so that we have time for you to speak about the financing issues connected to the Medicare beneficiary. Gretchen Jacobson is the Associate Director of the Kaiser Family Foundation's policy program.

GRETCHEN JACOBSON: Thank you and good afternoon. So I will explain the income and assets of Medicare beneficiaries now and in the future, to provide context for the extent to which future generations of beneficiaries can afford to absorb higher healthcare costs. As you may know, many people on Medicare lived on fixed incomes and the savings they set aside during their working years. How much they have in income and savings is tied to their life experiences including their education, health status, unemployment, investments and other such events. This work is based upon a model developed by Karen Smith and colleagues at the Urban Institute called the DYNASIM Micro-Stimulation Model. The model incorporates projections about the US economy including the recent economic downturn and recovery. I will show a lot of numbers, so two things to remember throughout are the following: first, all income and assets are on a per person basis. So for married people, income and assets are divided equally between spouses to calculate per capita amounts. And second, all projections are adjusted for inflation and earn 2013 dollars. So this research really gets to the core question of how affluent are people on Medicare?

Now what you see here is not your typical chart, so to help orient you, if you shrunk the Medicare population down to 100 people, each person would be represented by one of these gray boxes. In 2013, half of all people on Medicare had less than $23,500 in income. This is a median income of the population. And a quarter of all people in Medicare had less than $14,400 in income. At the other end of the distribution, 5% had more than $94,000 and 1% had more than $171,000 in income. So as you can see, most people on Medicare have modest means with relatively low incomes, but a small share have higher incomes. There are dramatic differences in the incomes of beneficiaries when you look at it from a demographic perspective, which is not surprising, given that their incomes are the result of their life experiences. Median per capita income is substantially higher among white beneficiaries than among black or Hispanic beneficiaries. And across all ages, income was lower among beneficiaries who were under the age of 65 and disabled. Among seniors, income declines with age and half of all beneficiaries who are ages 85 or older, had less than $18,000 in income in 2013. Married individuals had higher

per capita income than divorced, widowed or single beneficiaries. For example, half of all widows had less than $21,000 in income in 2013.

So next we examined whether the next generation of beneficiaries is predicted to have higher incomes than current beneficiaries. If so, this would have important implications for proposals to have future generations of beneficiaries pay a larger share of their costs. In 2030, the median income is predicted to be about $5,000 higher than in 2013. But it is not $5,000 across the board and upper income groups are projected to stay larger gains over the same time period. This is a good example of a dynamic where the rich do in fact get richer, where as the majority of beneficiaries at the lower end, see much smaller gains.

So we then looked at how much people have in their retirement nest eggs. This slide shows that in 2013, half of all beneficiaries had less than $61,000 in savings. To help put this in perspective, this is less than the average cost of one year in a nursing home and just as we saw with income, some has substantial savings, but the vast majority does not. One quarter of beneficiaries had less than $11,000 in savings, including 8% who had no savings or were in debt. At the other end of the distribution, 5% had more than a million dollars and 1% had more than three million dollars in savings.

Similar to income, when we look at savings across demographics, there is a large range. There are particularly large differences by race and ethnicity. Median per capita savings among white beneficiaries was eight times higher than among black or Hispanic beneficiaries. Savings among beneficiaries who are under the age of 65 and disabled, was lower than for seniors of any age group and among the seniors, those ages 85 and older had relatively low savings, which is a group most likely to need nursing home care.

When we look at the next generation of beneficiaries, we see the same dynamic where people in the bottom half see gains and savings of almost $40,000, which is relatively small compared to those at the upper end. In other words, there is little growth for most, but large gains and savings for a small percentage.

Lastly, we looked at the extent to which people on Medicare could draw upon the equity in their homes to help cover expenses. In 2013, half of all beneficiaries had less than $67,000 in home equity and a quarter of all beneficiaries had less than $12,000 including one in five who had no home equity at all. At the other end of the distribution, 5% had more than $400,000 and 1% had more than $800,000 in home equity. The difference in home equity across demographics followed a similar pattern to that of income and savings and while there are some growth projected in home equity among beneficiaries, most of the growth occurred among a small share at the top.

So to give a quick recap of what I have covered, quickly, while a small share of beneficiaries live on relatively high incomes, most people on Medicare have relatively modest means and half of all Medicare beneficiaries had less than $23,500 in income in

2013. The typical beneficiary has some savings in home equity, but it really ranges. Look into the future, income and assets are overall projected to be somewhat greater in 2030 than in 2013, yet most of the growth is projected among those with relatively high incomes and assets. As policy makers consider options for decreasing Medicare spending, these findings raise questions about the extent to which future generations of beneficiaries will have greater capacity than current beneficiaries to pay a larger share of their costs. Thank you.

ED HOWARD: Gretchen, can I just ask for clarification – I think you might have mentioned this but I want to make sure that everybody understands it and that I understand it correctly. When you do the projections, the numbers that you see are inflation adjusted.

GRETCHEN JACOBSON: Yes.

ED HOWARD: They are in constant dollars.

GRETCHEN JACOBSON: They are in 2013 dollars and adjusted for inflation.

ED HOWARD: Okay, very good. Thank you. We are going to turn next to Jim Capretta who is a visiting fellow at the American Enterprise Institute, senior fellow at the Ethics and Public Policy Center. Spent a number of years at OMB and in congressional staff positions. He has also sat on Alliance panels form time to time, for which we are very grateful. Jim?

JIM CAPRETTA: Thank you very much, I'm pleased to be here. I want to come at this from a slightly different perspective. I just want to talk a little bit about the nature of one type of reform and how to think about what its implications would be for teacher beneficiaries who I think there is a lot of confusion around it and it's an issue that is contentious, so therefore it has some noise around it that I think needs to be cleared up a little bit before we can evaluate alternative policies for thinking about Medicare.

To begin with, I want to start with an understanding of where we are with the large, private insurance component of Medicare called Medicare Advantage, relative to what it costs to provide services for a similarly situated person on the traditional fee for service program. It is quite often said and it's true that Medicare pays more for private insurance enrollment than it does for Medicare fee for service and that is related to a long tangled history of the payment structure for the Medicare program. How it pays the private insurance component. It used to be called Medicare Plus Choice, they revamped it a couple of different times, once in the 1990's, again in the early 2000's and altered it quite substantially in terms of how the payments were made to the plans. And as you can see on this chart, the payments, the maroon bar for what are paid to Medicare Advantage HMOs as well as all Medicare Advantage plans, exceed 100% of fee for service costs on average across the country, okay? So when people say we are overpaying Medicare

Advantage plans, that is usually what they mean. And this is from MedPac – the Medicare payment advisory commissions data that they compile every year, the last version was last summer. So that is one way to think about it. But it is not the same thing to say that a Medicare Advantage plan costs fee for service more as to say that Medicare Advantage is less efficient than fee for service. This is important for reasons of the topic today and I will bring it to you in a minute, but it turns out that the actual bids on an apples to apples basis when you look at what the Medicare Advantage plans are bidding to provide the same package of services as the statutory benefit under Medicare fee for service, but the bids are actually below fee for service cost on average across the country. This masks lots of geographic variation in high cost areas of the country, the differential is very, very large and in the low cost areas of the country, it is a little bit narrower and sometimes the Medicare Advantage plans can't be less expensive. But on average across the country, the Medicare Advantage plans are substantially below the cost of providing the same benefit services through the fee for service program. Now that is important because when one sees that, you can see that there is potential for savings to be had here, if one were to enroll more people into a private insurance component or some integrated system of care of some sort, it was bidding below the traditional fee for service package, you might be able to reduce costs and you might be able to reduce costs not just for the program itself, but also for the beneficiaries. Depending on how you split the savings.

Which brings me to the next slide, which is a summation of a long, pretty complicated report issued by the congressional budget office last September on an examination of what was called Premium [unintelligible]. This is the program to move Medicare toward a bidding system where the private plans would be bidding side by side with the traditional program and beneficiaries would be paying premiums relative to the cost of the different options they would select from. So in the typical example of how this would be structured in a region of the country, private plans would bid, fee for services cost would be measured by the government and an average big would be taken from those bids as well as the fee for service costs and if someone enrolled in the average cost plan, they would pay essentially what they do today under the Part B premium. But if they selected a more expensive plan, they would pay the difference between the cost of the average plan and the higher cost plan. If they selected a less expensive plan, they would be able to get a reduction in their premium. So this is essentially how Medicare Part D program was structured and the concept would be applied potentially to the larger program. Now CVO examined two ways of looking at this, one with the government's contribution to the program being set based on the average bid of the private plans and the government option. Traditional fee for service option. And the second approach was to set the government's contribution based on the second lowest bid, a little bit like the exchanges that were enacted in the healthcare law.

So what did CVO find? First thing they found was that when you move to a bidding system, and this is all relative to 2020 compared to current law. When you moved to a bidding system, the differential that we saw in the previous chart was on average – for the Medicare HMOs, about 8%, between their cost and fee for service. You add an additional

4% percentage points to the cost differential associated with it, moving toward a premium support type approach. Now they added three reasons why that was there. One was they attributed some cost savings to more intensive competition. They also think there would be more risk selection. They didn't quantify the magnitude of the different effects, but none the less, there is a 4% differential that they would say would occur. So now you have widened the gap a little bit further between what perhaps many HMOs around the country would be able to deliver and the cost of the traditional program itself.

And then, based on the enrollment of the beneficiaries, what would happen? Well, they assume that if you use the second lowest bid option, the total Medicare spending would be reduced by 11% and the beneficiaries however would be paying 11% more. Now what does that mean? It means basically that they assume that there would be a large differential that would be there between what many of the plans would charge and private plans throughout the country – in most regions of the country, not all. And the cost of fee for service and people who are enrolled in the fee for service program would be somewhat sticky and reluctant to jump out of fee for service and therefore would pay a higher premium. Okay? Now if you went to the alternative, instead of doing it based on the second lowest bid, but based on the average bid, which would be somewhat higher. And therefore the government contribution would be higher in many regions of the country. CVO estimated that the total federal cost would be reduced by about 4% in 2020 relative to current law and the beneficiaries would save themselves on average about 6%.

Now, I bring that up because in some ways I want to hammer home the point that I think that there is potential here for win-win. That is, depending on how a reform is designed in Medicare, it could reduce costs for the federal government and potentially reduce costs for the beneficiaries because there is a big delta out there that needs to be captured. And that is excessive utilization in the fee for service program. One reason why cost sharing is often discussed as an option for introduction to Medicare fee for service is because the current design of the program makes it completely ineffective. We have a very large cost sharing in Medicare by statute but a very small percentage of the beneficiary population is currently paying significant amounts at the point of service, in fee for service, because of wrap around insurance coverage from their employer, from the Medigap market and from Medicaid. And therefore, if you introduce cost sharing, it has the observed effect of, well, if the same utilization occurs and some of it is shifted onto the beneficiaries, they of course pay more. But what if increased cost sharing reduced unnecessary utilization? And people didn't spend money that they shouldn't be spending in the first place? What is the effect of that? Right? It's not the same thing as saying, well we are just shifting the cost onto the beneficiaries. And by every single definition, every examination from MedPac going back 20 years now is basically a hammering home of the point that there is a lot of excess utilization in the traditional fee for service program.

Let me go to the final chart, which is another misunderstood aspect of this debate and dynamic, which is that it's often said that Medicare has a great influence on the design and focus of the overall healthcare system and that is absolutely true. The fact that we

have a large, relatively inefficient fee for service structure in the United States, run through the Medicare program, heavily influences the fragmentation and overbuilt system we have that applies to everybody else. So it's a truism that Medicare is heavily influenced throughout the whole healthcare system. But one little known aspect of this is that if you integrate – if you have good integrated plans operating in the Medicare program, and they are having an effect on cost structures for those people enrolled in Medicare Advantage HMOs in particular, it has a good and positive spillover effect on the rest of the structure of the health system, including the rest of the Medicare program. So people often talk about spillover, it turns out that Medicare Advantage, when there is higher enrollment in low cost Medicare Advantage plans in regions of the country, it actually reduces cost in the fee for service side of the program as well, because it affects the cost structure and utilization system that applies beyond Medicare Advantage. And that is what this data shows. Now, this is not the only study that has confirmed this, this has been confirmed in many, many studies going back a long time, but the most recent one I can remember and find was by Michael [name] and colleagues, that showed essentially that a 1% increase in the Medicare HMO penetration rate in a community, lowered fee for service spending in that same community by .9%.

So I think the notion that the solution here is to move a lot of people out of the Medicare HMO market, back into the traditional program, which some people believe, I think is actually false and would backfire and result in the opposite of the intended effect. Thank you.

ED HOWARD: Thank you, Jim. Batting clean up, we have Marilyn Moon. She is a health economist of national note, former Medicare and Social Security trustee. And in the interest of full disclosure, a senior staff member of the Pepper Commission some years ago, where a certain Alliance Executive Vice President was the council. So I cannot claim objectivity, she is brilliant and she is back and gracing our dais. Thanks very much Marilyn.

MARILYN MOON: Thank you, Ed, it's nice to be here. Ed and I were both 12 when we served on the Pepper Commission a long time ago. But it's amazing how the issues don't seem to change very much. In fact, it's kind of scary to think about that sometimes. I didn't bring slides today because I figured batting cleanup, as I am, that I would be able to pick up on what a number of other people said and use their slides if necessary. Kaiser always has wonderful slides, so I find I can definitely do that. So I want to say a couple of things preliminarily that kind of reflect what other people have said, before I make a couple of comments that I had wanted to talk about before I got here today.

I think that all of the presentations you have heard so far have a lot of food for thought. This is a really tough area and the longer I work in this area, the more I am convinced it's hard to find easy solutions. But I think it's also important to recognize that we should look for solutions that are appropriate to the problem, as opposed to solutions that meet our priors in some way. And that is sometimes a difficult thing to do.

Dan Perry was telling us a little bit about a number of issues that I think the implications are that we need to tackle the reasons for the high cost. And I think Jim was talking about that as well to a certain extent. You really need to find ways to go after that and that does not normally mean, stick it to the beneficiary. In fact, if you look at that chart that shows you what the spending is, if you stick it to 85% of the beneficiaries, you are not going to get much of an impact at all. There is just not much money to be gotten there. And if you are in that top 15%, you are very sick, you are well in the hands of the healthcare system. A little copay here and there is not going to have very much impact on your behavior. In fact, it is probably the last thing on your mind. So I think that the implications from some of what Jim what saying about smarter plans and what Dan was saying about the distribution of costs and the need for research in this area to find better treatment, are both on the mark in terms of that and something we should think about.

Another element of this that they didn't raise, is that if you look at where healthcare spending costs begin to rise in the United States; it's not at age 65. No magic number there. It is really in your 50s. In fact, for those of you out there who are young 'uns and in your 50s, get scared, because if you look at the charts, you know, drug usage pretty low, you hit 50 and suddenly you are taking statins, you are taking antacids, you are taking all sorts of other things. You also – this is depressing, isn't it, Tricia? You are also facing a lot of other things such as increases in the chance of developing diabetes, developing cancer, developing heart disease, etcetera. So one of the things that we should definitely be thinking about in terms of tackling some of these problems, is that this is not an aging problem of 65 and over. This is an aging population problem that begins all the way back into the 50s and maybe even earlier in some cases. So that is something really important to remember. Now, one piece of good news about that is that we should get a boost from the ACA from this. One of the little known things that people don't talk so much about it, if you look at the research on costs of Medicare, for people who come onto the Medicare program who have had no insurance, they spend about 15% more, not just for one year, not just for two years, but for up to ten years of their life after they go onto Medicare. They come on sicker, they come on with more problems, we could do a lot to help in that case. So if the ACA allows people to get insurance, that itself will be a boon. And I think that underscores the fact that we are talking about earlier onset issues.

I have already mentioned that cost sharing is likely to be of limited value in many cases. I think we also have to take care and our assumption is generally about using economics for disciplining a lot of things. I really have great – much greater faith in the David Drew clinic and cyber knife, than I do in cost sharing. This morning as I got up and listened to WTOP as I usually do, they were telling me I should go to a Nova health center – it used to be Georgetown; I think they stopped using cyber knife or something. But now cyber knife is at Nova and therefore I should go there to get my care. Or the David Drew clinic that wants to test me head to toe from the time I am 40 on every year and with that wonderful executive thing, they will find lots of things to look at and spend on. We do overspend in the United States, but part of that is due to our healthcare system and our

very much for profit healthcare system that pushes all of those things on individuals. I don't know many people who sit around and say, gee, I think I would like to get a few extra benefits this year, so I think I will visit the doctor a few more times. I think I will ask for some more medication, etcetera. People get convinced to do that when they are told that there are things that are really important for them to do.

Gretchen Jacobson reminds us that people are not as well off as they sometimes are thought. Robert Samuelson should be listening to this report, who recently said we should stop coddling those seniors in part because indeed it is true that seniors have faired better in the approximately last ten years than the rest of the population, but that is a little bit like penalizing people that just sort of held equal while recognizing that other people have gone downhill. I guess Samuelson wants everybody to be as miserable as he thinks he is or other people are. But the other important point in terms of these data that you look at, that I think people have to understand, is that when you talk about changes in well being for seniors, these numbers, which are not very optimistic, have to be thought of in the context that they are actually more optimistic than what individuals themselves face. And that is, if you think about the population 65 and over, how well off are they? You get a boost from the fact that people who are aging have had longer life spans, healthier life spans, greater earnings and so forth up until fairly recently anyway. And that is important to remember. But it also is the, who goes in and who goes out of that pool. Every year we get – and Dan was telling us how many people there are that turned 65 – lots new entrance into the age 65 and over pool. And they are all healthier and wealthier than the ones exiting that pool, who die every year. And as a consequence, that lifts those numbers to look greater on average in terms of increases for example, then when you look at the population as a whole. Take a thought experiment, and I'm actually working on a little paper on this, in which instead of doing that, you follow the same cohort through time. You take someone who is 60 in '97 and then in 2002, who is 65 and then in 2007 is 70 and so on and what you find is that their incomes are going down, they are not going up. They are not even stable, they are actually falling. We know that people use up their resources with healthcare problems. Other things happen. They stop working, even though people are working a little longer than in the past. So those are challenges. So when we put this in the context of looking at policy changes, I think that the first thing I would say is, look at policy change as dialing for dollars and be skeptical. Instead we need to think of what are actually good policy changes? Home health co-pay is one of the worst ideas to come down the pike in a long time. Let's see, 85 year old ladies who have broken their hips are the big numbers of folks who are in home health. Let's go out and grab them and charge them a little co-pay and we will all feel better off. And I'm sure they will change their behavior. The reason people talk about it, is because home health costs are going up. The reason they are going up is because we do have a bad payment system that is rewarding home health agencies who ripped off the system. The number of home health agencies – actually, if we could get Texas and Florida out of the United States, I think that our home health numbers would look a whole lot better. Lets let them secede and home health would look fine and we could stop talking about home health co-

pays. Go for the policy change where it is needed and that is in terms of the way the payment policy is.

And I barely have time to talk about the higher income means testing that I think is really important that people are talking about. It sounds so painless at $85,000. Yes, those people are pretty well off, although certainly they don't even make middle class as far as tax policy is concerned in the United States. That is $250,000 as a cut off. But remember that these things are going to deteriorate over time and in ten years, the equivalent of having about $65,000 of income means that the part B premium you will be paying will be double if the numbers are right from what just came out from the AP in terms of what it looks like the President may be proposing. And if you don't look at those numbers and look a little further ahead, look at the article that the Kaiser people brought you. Again, not a bad idea to go after higher income individuals, but lets not go after higher income individuals just in order to dial for the dollars. Let's think about how to do it in a smart way. And whoever thought a good policy was to declare that wealthy meant you were in the top quarter of the distribution of a population that the numbers that you have seen today show as not a very wealthy population. Just claiming that one quarter of the people should be paying more and are wealthy, doesn't make it so. If I were a queen, I would say I could go along with some of those changes. If you turned around and did other policy changes that were necessary such as increasing low income protections.

And I'm sorry for going over, but I got passionate.

ED HOWARD: Okay. Time for you guys to get passionate. There are microphones that you can use to ask questions. If you do that, please identify yourself, give us your institutional affiliation and keep your question as brief as you possibly can. There are also green question cards, you can write a question on it and hold it up and someone will magically bring it forward so that we can have the panel address it. And you get the first question.

KATY ADAMSON: Hi, I'm Katy Adamson with the YMCA of the USA, how are you? Today more than half of all Medicare recipients have pre-diabetes. Today, by the end of this decade, one in two adults will have diabetes or pre-diabetes, so those folks that are going to go into Medicare. NIH and CDC have shown us that we have a tremendous opportunity to reverse the course of diabetes through the diabetes prevention program. In fact, the DPP showed that a 71% reduction in the incidence of – for those over 60, through the diabetes prevention program. We only spend one to three percent of our healthcare dollars on preventing disease, the same diseases that cost us 75% to 80% of our healthcare dollars to treat. How do we ever expect to reverse the course of the costs in Medicare?

MARILYN MOON: I think that is a great example, because that is one of the areas in which you can really have an impact. We know that you can deal with the diabetes issue, you can treat it, you can hold the cost down and we don't do very much. I totally agree

with that. I will even say something nice about private plans. One of the things that some of the new evidence about private Medicare Advantage plan shows, is that where they are saving dollars, where they seem to be more efficient is in terms of management of some of these kinds of challenges. So I do think that this is an area that you are going to have to put a little bit of dollars out there in terms of investment, but it could pay big dividends.

DAN PERRY: I would just simply say, amen to that. The slide that I showed earlier, just to recap, showed that the six major chronic diseases associated with aging are all today at or above 100 billion dollars a year, diabetes being one of those and the amount that we are putting into understanding the disease, understanding how to curb it, prevent it, postpone it, through in many cases lifestyle interventions as in the case of cardiovascular and some diabetes, is – it is a national scandal. And the National Institutes of Health have lost a tremendous amount of their funds in the last ten years because of inflation and healthcare costs – or and research costs, even as their budgets have been kept flat. So when you look at other policy issues, don't overlook NIH, because that investment is one of the slender reeds that we have in hopes that we will see fewer instances and less cost from age related diseases in the future.

ED HOWARD: Yes, go on.

STEPHEN SPITZ: Yes, my name is Stephen Spitz and I'm a Medicare beneficiary and I have a simple question. The Nobel Prize winning economist Joe Stiglets has said that we can save one half of a trillion dollars over ten years by allowing the government to negotiate drug prices with the drug companies under Medicare part D. Can you please comment?

ED HOWARD: Jim, do you want to do that?

JIM CAPRETTA: I think the answer is that, he may say that, but the Congressional budget office wouldn't say that. And so it's – just because one economist has a projection that comes out something like that, doesn't necessarily make it something that a Congress could act on and save that much money. Now, the last time our CDOs revisited this question a number of times since the drug law was enacted and I would say a couple things about this. Number one is that when they estimated the bill originally, they vastly over estimated the prices that the private plans would be paying under the formularies for prescription drugs. So they misestimated the effect of private plan competition on the prices paid by the drug companies. Prices paid to the drug companies. The second thing is that the dynamic over time has been to keep the cost of the program very low relative to what was expected and actually low by any standard. And so if you introduce at this point, something that would move away from the current construction, you have a pretty heavy burden, I think, to prove that it was going to result in something better. Because the programs work pretty well in terms of both cost and coverage. The third thing is that if you move in the United States to a totally regulated system of pricing of pharmaceuticals, which is a possibility, that would basically make that the same through

– one reason why the United States pays relatively higher price is that every other country in the world also has heavily regulated prices for drugs. And the question is, what would happen if you just move to that as a regime globally? Would there be the same kind of incentive to move on the products that they are trying to move on in the future? I think there is pretty good evidence that the answer to that would be no, but there is a big debate about that.

MARILYN MOON: I don't believe that we should go to a system of fully regulated prices. I think that would be hard to do, but I do think there is some room there and I think there is a lot f outrageous stuff that goes on in terms of the cost of prescription drugs. And there are a number of examples that people have cited pretty recently. I also think that we should be a little careful about part D. Part D did turn out to be less expensive than they thought, but also we know that several other things were happening at the same time and that is that tons of drugs were coming off of patent and the one thing that the part D plans did very well was push people into generics. That was something that they did and it was useful. That is not necessarily because of the wonders of competition, but in this particular case, because it was the right time and the right place and a good policy that they undertook. So I think we shouldn't be too complacent about how wonderful part D was.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin, I am a primary care physician, I am a Medicare beneficiary and a widow. I pay three times I think the normal – because I have been able to keep the job, the normal – the minimum part B premium. It is a lot. The three times. With regard to drugs, I also work for a law firm that sues drugs for off label marketing. The amount that they charge is ridiculous, it has absolutely nothing to do with research and development, it has everything to do with Wall Street. And if we didn't incent pharmaceutical manufacturers who make cancer drugs to develop a drug that gives you one extra month and costs twice as much, that is in thousands of dollars for say, $5000 a month to $10,000 a month. That is a drug that we just sued. It wouldn't necessarily be so bad. Maybe that money should be invested in something else and that brings me to my original question, which was, nobody has really mentioned here social services for the elderly. I mean, 50 years ago everybody had a daughter who wasn't married who could come and take care of them or there was family living close by who could keep an eye on an aging relative, maybe bring them groceries, maybe take them to the doctor's office. Maybe help them think through something that was complicated, like 15 medications. Well, we don't have any of that now and it's nice that the hospitals are following up when they discharge people, but these services are no long considered medicine. And Medicare doesn't pay for them. Medicaid sometimes does. But they would save money and they should not be for profit, they should be offered by the community, Bob Grist, who is here, has done work in that area, so has Joanne Lynn, but in thinking about how to reduce the cost of Medicare, we ought to think about providing the social support, which they do in Europe. And that is one reason they get better outcomes for more people at lower cost. Everyone agrees?

ED HOWARD: My guess is, don't you agree? Okay, yes.

JULIA MOORE: I think the panel does agree that most of the policy debate focuses on those 85% of recipients and not the 15% of recipients that are responsible for 75% of the cost.

ED HOWARD: Would you mind identifying yourself?

JULIA MOORE: Julia Moore with a few charitable trusts and I am not a Medicare recipient. Could the panel provide policy solutions, which it thinks are viable and significant for that 15% of the Medicare population, particularly in regards to utilization of healthcare that does not necessarily either significantly extend or improve quality of life.

TRICIA NEUMAN: Well, that is a terrific question; I'm looking in all directions to see who wants to answer. We have had a number of ideas put on the table. People have talked about delivery system reforms, people have talked about targeted interventions, people have talked about cost sharing, people have talked about managed care. People have talked about preventing those things from occurring in the first place. But what does the panel think about how do you really target the high cost population? The subset of people who account for such a disproportionate share of spending? If the goal of the public policy here is to go where the excess spending is occurring.

JIM CAPRETTA: A couple things to mention here. One is that it is quite true that a large portion of the spending is concentrated on the 15%, but its not the same 15% every year. It's heavy dominated by a certain core group, but there is some turnover in that population. And as there is in the under 65 population with the high cost cases. So you don't necessarily know in advance every year exactly who the high cost cases are gonna be. The second thing is that if someone is in an integrated system of care prior to the onset or need for a very expensive acute care, a likelihood of keeping the costs under control are much, much higher than if they are in the traditional program. Even with all of the experimentations going on today. So I would say that it's a complicated situation, but one does not – just because the population is – the costs are concentrated in a small percentage of the population, doesn't mean a broad based reform wouldn't lead to more people, even including that percentage of the population, being in better integrated plans if you added more competitive system, like premium support could bring about. So I still think the evidence would indicate that moving toward something where people have an incentive early in their retirement years to enroll in integrative systems of care, is the best solution to them needing better management of the care over the long run.

DAN PERRY: I don't know if this is taking another side, but let me speak for the 15%. Since there is so much costs that are run up because of poor management of geriatric conditions – multiple geriatric conditions and so little emphasis on research and applications of good geriatric practices of this population. I think it is certainly a target

rich environment for better policies. In the US we do an abysmal job in training health professionals in geriatric medicine. You cannot get a medical degree in this country, or for that matter nursing, without doing a rotation in pediatric medicine. And yet, the number of medical schools that require a rotation in geriatric medicine is about 10%. And of the 90% that can choose as an elective as part of their training to take a class in geriatric medicine, the annual survey of medical school shows about 3% of medical students will choose to take a course. The reasons have been well studied – you make less money because you are being paid by Medicare which pays less than the going rate. You are seeing all old people and its not – they don't make a TV show about docs that see old people and make it look glamorous. It is considered low status, I mean, we can go on and on. But if we really want to get at some of the costs associated with Medicare, we need to think about geriatricizing, if that is a word, our healthcare delivery system.

TRICIA NEUMAN: We have a batch of questions that have to do with the low income population, so I'm going to try to pull them together and get our panelists to talk about it. So one is, people talked about low income protections that might accompany some of the Medicare savings proposals. What kind of low income protections do you have in mind? There are two questions related to that. And then the third question is, when you think about current Medicare protections for the low income populations – Medicare savings programs, coverage under Medicaid for dual eligibles, how does that stack up to what is available under the ACA, assuming the full Medicaid expansion and the subsidies? So kind of two types of different questions related to the low income population.

GRETCHEN JACOBSON: I will easily answer the second question. So for those of you who don't know, under the ACA Medicaid eligibility was expanded for people who are not Medicare eligible. So it's the same income and asset thresholds that applied prior to the ACA. So there will be a share of people who when they turn 65, if they were on Medicare or they were receiving subsidies, will no longer be receiving subsides once they go onto Medicare. And I think that is something that policy makers are very aware of and are trying to think of and look at what that population is and how many people will be affected by that.

ED HOWARD: Gretchen, can you elaborate where those people might fit in income and disability status or anything else?

GRETCHEN JACOBOSON: The biggest difference is, or the clearest, I should say, is under the ACA there is no asset test for people who are not eligible for Medicare for them to qualify for Medicaid. Whereas once they turn 65 and go on to Medicaid, they will be subject to an asset test that for Medicare can be about $2,000, which might really affect some people.

MARILYN MOON: And the most generous income protections for seniors are for prescription drugs at 150% and then protections go – of the federal poverty level and then the protections go down from that. 150% is about $18,000 or so a year of income, so

anybody with income above that is not eligible for any kind of special protections unless they have spent down and become totally impoverished to go on to the Medicaid program. And to put that into some context, those protections have not improved as a share of income, even though the amount of income that people pay towards the cost of their healthcare have gone up every year as healthcare inflation has far exceeded the rate of growth of incomes for those individuals. So there has been a real deterioration in the last 20 years in the low income protection with no improvement on the horizon, I think.

TRICIA NEUMAN: Can we go back to the first set of questions that had to do with improvements for people with low incomes? Even within the context of the deficit and debt reduction discussions, the bipartisan policy center came out with a benefit redesigned that included low income protections, which meant lower cost sharing for people with lower incomes. What other ideas are on the table? Marilyn you had mentioned that you thought there shouldn't be more on the high end unless there is something that is more protective on the low end. Did you have anything in particular in mind?

MARILYN MOON: Well, I guess what I had in mind is that it used to be that we talked about low income protections going through Medicaid because it was kind of considered inappropriate to distinguish among beneficiaries on Medicare, since Medicare was applied to everyone equally and we got rid of that some time ago. And now we are talking about marching down the income scale in terms of looking at who will pay higher premiums. So from that standpoint, there is no reason why we couldn't incorporate that as part of the regular Medicare program and ask people who have special needs, so that you think of it more as a continuum than it currently is in terms of things like premiums and cautionary protections. I think also if we ever move to upper limit protections in terms of stop loss, the only way that stop loss is likely to be considered affordable by people who are talking about policy, is if it would be an income related stop loss. Because if you talk about $7,000 - $8,000 as a stop loss protection and for someone with $17,000 or $18,000 of income, that is not very reassuring. If you talk about it for somebody who has got a lot higher income, then it is reasonable protection.

SETH TRUGAR: Hi, I am Seth Trugar, I'm an emergency physician and I work in the office of Congressman John Dingle in the House, I'm not a Medicare beneficiary, but I hope to be someday. But I do practice medicine and so I do benefit from Medicare quite a bit. One of the things that we have been learning from the IOM report on waste and 30% of waste – spending in the system is wasteful and all the ideas that you all have been mentioning today, there is an astounding amount of low hanging fruit both to save money and improve care and quality of life for Medicare beneficiaries and patients in general from things like integrated care delivery, long term care management, better geriatric care, better social services, community outreach, etcetera, etcetera. Not paying billions and billions for non-beneficial surgical procedures and things like that. What seems to be the problem is not a policy problem, but a politics problem and I think end of life care is probably both the biggest example and the biggest price tag for all of this. That we can do

a much better job of taking care of people at the end of life and respecting people's wishes and doing what people want and not turning patients into money making machines, essentially. The question is, is there a way we can get there from here with our current political system?

TRICIA NEUMAN: I will take a stab at that one. That is a very difficult question and it has proven to be a very difficult political and policy issue here on Capitol Hill as you are recalling from death panels, etcetera. I mean, in many respects this is an issue that may be best addressed outside of a political and policy context, because a lot of what you have just talked about can be addressed in discussions between physicians and families and patients and better communications in that area. Better training for physicians, all along the process. So it may be that you have actually identified an issue that is best addressed outside of a political and policy context, but actually could be addressed with better education, better communication, and I think that is an area where more could definitely be done and it would make patients happier and reduce costs.

MARILYN MOON: In theory, an integrated healthcare system ought to be able to handle this, because that is where the low hanging fruit is, as you said. And I think that although – and I'm much less of a skeptic and critic of Medicare Advantage plans than I used to be, because I think they have kind of grown up and gotten better in many cases, partially because they have been forced to get a little better. But I haven't seen them be very creative as yet in terms of doing some of those kinds of things. And I think that is kind of the next step. The special needs plans, for example, have not particularly demonstrated that they are doing a great job out there, they certainly haven't grown particularly. But it doesn't even have to be a special needs plan. Why shouldn't a good integrated healthcare system really take those things on and use some of the dollars it gets from Medicare that it is saving presumably by doing less of other things and move them into those areas. And once they do that, then you will see me also pounding the table and saying Medicare Advantage, yahoo. So not yet.

ED HOWARD: I should point out, by the way, that despite the political delicacy, if you will, there are bipartisan proposals in both the House and the Senate that would address palliative care as distinguished necessarily from end of life care. Mr. Blumenauer and Dr. Rowe in the House and Mr. Warner and Mr. Isakson in the Senate. I commend those proposals to you.

TRICIA NEUMAN: This is a question for Jim, but I think anybody else could handle it because it is a pretty tricky question, so if you want some help, there is some other panelists that might want to weigh in. determining what services are unnecessary requires Congress to tackle how it best defines medically necessary services. Will Congress have the wherewithal to get at this root issue?

JIM CAPRELLA: No. I wouldn't actually put it that way, that – there is a landmark study of utilization done by Rand, you know, 35 years ago so it was the only time we

were able to actually do a study on people and have their health utilization tracked, now nobody wants to do it because there are so many ethical implications associated with it. But anyway, they did track it pretty carefully and utilization was associated with a reduction both in unnecessary as well as what people thought would have been useful care for that population. But their health status did not deteriorate at all. So I would say that the idea that putting some additional cost on the use of service at the point of service wouldn't be able to distinguish totally between necessary and unnecessary care. I'm not convinced that that is the case. I think that by and large the things that people view in the system as being outside the realm of what would be normalized and good standard of care would tend to fall away and then to the extent that we had to incent good use of services, we maybe have to look into an additional policy or two. But there is so much unnecessary use out there if we are reflexively nervous about trying to address it through cautionary. And I think we are going to have a lot of problems.

ED HOWARD: Jim, I got another one, I think other panelists would be interested in this as well. You talked about comparing the fee for service spending with the spending by HMOs in Medicare Advantage program and I wonder – the question is framed as saying, are HMOs the best insurance design choice for seniors and people with disabilities on Medicare? But more broadly, is there a way to use the other managed care entities? The PPOs that are now outstripping HMO enrollment to accomplish the same goals?

JIM CAPRELLA: Yes, to some degree, but the real key with the senior population. I think with the population in general and others I'm sure will have views on these things, is genuine integrated care, which is a lot different than just creating a network and negotiating a physician fee schedule with a preferred network. So you know, more real integrated care where they are genuinely having teams of physicians working together, working with an inpatient system, trying to keep people out of the hospital, being proactive in their outreach to the population they are managing and also having protocols for use of services once you get into their system. I mean, I think there is a real difference between a loosely run PPO and a real integrated system where they actually have tracking of data and data protocols to say, okay, when you enter our system and you have these indications and you are this age with this problem and this problem and this problem, here is what we do to you. And we have tracked that over 50 years and we have improved the process for tracking that population through the system over many years. That is a big difference than just saying, well, here is our network and go use any physician you want. So I think part of this is, what are we talking about? And I think the genuine integrated care systems have a much more higher potential.

ED HOWARD: If I can follow up, I would be interested in what the panelists think in that context about the growth of ACOs – Accountable Care Organizations. We just announced another 100 odd additional entities that are presumably moving toward the kind of integrated care or at least coordinated care that Jim was talking about. Is that a way out of this box? We have lots of economists here.

MARILYN MOON: I think this is a very difficult area. I think that the goal is a notable one and that is for people who are reluctant to, or for whom their aren't good plans in an area, that people who are just not going to go into the very integrated systems that Jim was talking about, then the question is, short of forcing them in there, how do we deal with trying to improve the world around them in ways that make sense? And from that standpoint, I think it is a good idea. Doing it is very difficult in practice. My favorite notion was that when ACOs were conceived, we weren't going to let anybody know they were in an ACO, it was going to kind of a little secret between the doctors who were coordinating care and steering you in places and they weren't going to tell you, which I think seems kind of silly, especially if what you really want is for people to actually go to networks and organizations that have agreed to work together. So I think we have to find ways short of people committing to a very closed system, at least for a while and to convince people that that is going to work and try that out. I think it's a useful thing to try, I'm just not sure its going to work very well, because there is not a lot in it for the beneficiary at this point in time, necessarily.

JIM CAPRETTA: Just one quick thing, but on the ACOs, as Marilyn indicated, the statute hasn't abandoned the point you just made, which is that the way someone is enrolled in an ACO is by virtue of their use of a primary care physician. If their primary care physician is part of an ACO, and the database shows that that is the physician that that beneficiary uses the most often, then they are by default enrolled in the ACO. Now they are then told by a letter that they may or may not read and informed that they can dis-enroll through a process they may or may not understand. But the truth is, the vast majority of the Medicare population that is now today enrolled in these supposed ACOs had no earthly idea they are in these ACOs.

ED HOWARD: Gretchen and Dan both want to weigh in?

GRETCHEN JACOBSON: I would just add that, as a lot of people know, we don't have a uniform health system and Medicare doesn't look the same in different parts of the country. So you don't – for that reason, you don't see a lot of HMOs in rural areas. You see a lot of PPOs because there aren't a lot of doctors in those areas for a health plan to contract with and from which to choose. And so it looks very different in different parts of the country as how an HMO would operate or how a PPO would operate in different areas. And the same with ACOs. Everything depends upon on what the healthcare system looks like in that part of the country.

DAN PERRY: I don't know if Accountable Care Organizations are going to be the vehicle by which we deliver well integrated coordinated good care for geriatric populations, but it has long been an article of faith that the best way to treat a prototypical 85 year old woman with congestive heart failure and incipient diabetes and some cognitive deficits and difficulty in moving about, is to deal with her in the context of a well coordinated team that is looking at her nutrition and her care giving needs as well as the numbers on her chart and the progression of her various diseases. That is the way we

deliver good and efficient geriatric care, whether any of the forms – reforms that are on the table are going to get us there, I don't know.

TRICIA NEUMAN: I will say, there are so many different models that are being tested, that have been launched by the Affordable Care Act. ACOs is one of them, but there are numerous – dozens and dozens of models that are being tested and I think we are very early on in the process of trying to understand what the effects might be. There are, for example, demonstrations to reduce hospital admissions and readmissions and emergency room visits among nursing home patients. They are a high cost population. There are others and most of the research has shown that to the extent demonstrations or programs are able to target the highest need populations, just to come back full circle to Dan's point about high cost people, the more likely they are to be effective and I think we are at the beginning of a learning curve in trying to understand what are the attributes of these different models that may work or not work in improving care, reducing excess utilization and slowing spending for these high cost patients.

ED HOWARD: Dan, you had a slide that showed the explosion of chronic care that we were expecting over the course of the next period of decades. And from my – I used to be an aging person with the House Aging Committee, now I'm just an aging person. But when I was an Aging person, we heard a lot of talk about something called "squaring the demographic curve", that the way science would develop would allow, it was hoped, that people would, as the old song said, lived until they died. And that there would be a shorter period of chronic illness and therefore presumably a lower expense, but also a lot less pain and suffering. How are we doing on that front?

DAN PERRY: Well it's – if I said it was a mixed bag, I would be giving it more credit than it probably is worth. I think it has always been the goal, has been to keep people through their 70's, 80's and 90's as free of those chronic diseases as possible by delaying their onset, by better management and by health promotion. But the numbers frankly Ed, are just overwhelming us. The numbers of multiply chronic diseases at one time in this population. I mean, all of the slides that I showed, kind of show where we are now, but we are talking about in many cases, tripling or even higher numbers of some of the most expensive diseases. Tell me how we are going to be able to absorb a trillion dollar cost every year for Alzheimer's alone in 2050 and I will say we have solved most of our problems. Because all of those bars are going up by double or triple. The good news from the research side is that increasingly there is a consensus that we can identify the small number of underlining biological mechanisms that are driving all of these diseases alike. Cell turnover and cell death, stress response, chronic inflammation, we now know the names of the mechanisms that drive the human aging process and there is a lot of excitement now at NIH between institutes that previously were only looking at one disease at a time, at getting at these underlying drivers of the mechanisms themselves. And therein lies a great deal of excitement and hope for squaring the curve. More people get closer to the end of life to a minimum period of time when you are in a steep decline. That is the hope.

MARILYN MOON: Okay, here is a practical question for the panel. This relates to the SGR. Replacing the SGR formula. What are your ideas for how to pay for repealing and replacing the SGR formula, which over ten years would be over 100 billion dollars? Anybody have any ideas that they would like to put on the table?

ED HOWARD: Feel free to contribute amounts of lesser than 100 billion if you have ideas that would be useful. We might cumulate them. Jim?

JIM CAPRETTA: Well, in Washington you always answered the question you wanted to hear, not the question that was asked. The question I want to answer is, is repealing the SGR and replacing it with the formulas that have been talked about in the House and Senate bipartisan bills, is that a good idea that we went out scramble and find 100 billion dollars and pay for? My answer to that is no. The idea – this is a wish and a hope, the idea that we have some magical new way of paying physicians that will be worth 100 billion dollars, that will bring about this quality movement and revolution in Medicare, I think is not true and so therefore I think the idea of scrambling to put another 100 billion dollars into essentially the fee for service delivery system in Medicare, I just don't think that is a good idea. I think that basically is a lot of money into the current system and I would be very reluctant to do that.

ED HOWARD: Marilyn, any ideas that pop into your head?

MARILYN MOON: Yeah, what is the alternative question? I think that we can't ignore however the problem that the SGR raises and that is of alienating physicians from treating a population that we are not ready to ask some 30 million people to suddenly go into non-existent integrated care plans. So I think that it would be nice to say we shouldn't do it and just move on, but I think we are going to need to do something. I don't believe that all things, all policies are treated equally in the United States when we are talking about what we need to do to resolve them when people have – are in the mood, they simply wave their hands and say, we don't need to worry about that. That is what we did in terms of, for example, reinstating or keeping the Bush tax cuts a couple of years ago. So I do the same policy as the Bush tax cuts.

ED HOWARD: As we get down to the last few minutes here, I ask you to pull out those blue evaluation forms and fill them out while we hear the last question or two and we will hear a question from Tricia Neuman.

TRICIA NEUMAN: Okay, this is not my question, but it is a question I'm asking, which is about some of the Medigap proposals. So there was one set of ideas that would prohibit first dollar coverage and there is another under Medigap employer plans and that has been proposed by several entities. There is another idea that would impose Medigap premium surcharges, so people who purchase policies would have to pay a higher premium or essentially a tax because they are buying a Medigap policy and because as

Jim said earlier, it is assumed that people with supplemental coverage end up us Medicare services. So they are basically paying for that. I guess the question is, do people want to comment about these Medigap proposals in terms of what the effects will be? Will they lower utilization appropriately? What will be the effect on premiums? Generally what are your comments on these Medigap proposals?

JIM CAPRETTA: I am for them, so of the alternative ones you have put on the table just there, I would probably favor more the approach that went in and said, we shouldn't be having plans that are filling entirely a public insurance program's cost sharing structure because it drives up cost for tax payers too. So there is a public interest in understanding how these two things interact and I think unquestionably from CVO on down, it would reduce utilization. It gets back to the question of whether you think it's unnecessary or necessary care. My strong inclination is to assume that that system will weed out the necessary much more than the necessary and think of this other interaction, we have a large number of Americans through the military health system, for the federal employee health system and through state and local retiree wrap around plans, where tax payers and paying essentially for a portion of Medicare part B. They are also paying for the retiree subsidy for wrap around plans for public employees who are retired to get their cost sharing entirely reduced in the public insurance program down to zero. So the tax payers are paying a lot of money for wrap around plans through public employee systems, to wrap around the Medicare program. It's billions of dollars. It makes no sense whatsoever and that ought to be coordinated at a minimum.

MARILYN MOON: I think that you could do some things to discourage first dollar coverage, but if I were going to do that, again, I wouldn't make it a totally punitive policy, I would then improve the protections that exist in the Medicare program. I would relook at the way in which the cost sharing is done. It's a totally wacky cost sharing system that doesn't make any sense to have an enormous part A deductible for example. To have no upper bound limit on cost sharing. I would make it look much more like other Medicare, look much more like other plans that out there now. And that is easier to do than it used to be because people have raised their cost sharing over time and you wouldn't have to make enormous numbers of tweaks in it. And then you could, I think, put a number of controls on the purchase of Medigap, but if you did that, you would have a lot of people who could have the option of then not buying Medigap rather than forcing them into having to buy plans and pay penalties because they don't want to have the out of pocket limit problem that they do now.

GRETCHEN JACOBSON: I would also just point – in your packets you will see that there is a brief that talks about different Medigap proposals and looks at the most recently available data on Medigap. And as part of that, it also shows the geographic variation and who has Medigap and its really specific states really have high shares of Medicare beneficiaries with Medigap and that is just something to consider that this is not something that is across the board, uniform across the country. Also another thing to consider is its really very – the effects may really vary depending upon whether this

affects current beneficiaries or whether current beneficiaries are grandfathered and it only affects future beneficiaries. So there is just a lot of different components to consider in different Medigap proposals.

ED HOWARD: That sounds like an authoritative last word. We have come to the end of our time here. Reminding you to fill out your blue evaluation forms, if you would. Let me just take the time to thank our colleagues at the Kaiser Family Foundation, not only for co-sponsoring, but for obviously making a very substantial contribution to the dialogue directly. Thank you for some very good questions and I ask you to join me in thanking the panel for some very good answers. And I should say, as a commercial, if you want to come back in about 10 days, we have a program on the SGR where we will solicit some of those 100 billion ideas.