Medicare as a Building Block for Health Reform: Should Americans Buy In?
Alliance for Health Reform and Commonwealth Fund
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ED HOWARD, J.D.: My name is Ed Howard. I am with the Alliance for Health Reform and on behalf of Senator Rockefeller and Senator Collins and our board of directors; I want to welcome you to this briefing on focusing on ways to use Medicare as a model to move toward health coverage for all Americans.

Our partner in today's program is the Commonwealth Fund. As most of you know, it is century-old philanthropy based in New York City that supports work on a whole range of health policy issues with an emphasis on vulnerable populations. We are very pleased to have the president of the Fund, Karen Davis, with us to introduce the topic and help moderate.

Now we know that both Senator Obama and Senator McCain have proposed ways to broaden healthcare coverage in the United States though certainly, Mr. Obama has a more ambitious plan than Mr. McCain does. There may be differing views on whether we ought to strive for universal coverage though there are many Republicans and Democrats who do endorse that goal. The trick is how do you do it?

The Commonwealth Fund has actually given us our starting point for today's discussion of that issue. It is a set of building blocks, if you will, that the authors propose, aimed at reaching nearly universal coverage with relatively

little disruption in current coverage patterns and with relatively low government costs using Medicare as a main platform on which to build those expansions.

Now before I introduce my co-moderator and we move to the panel, I just want to clarify a few logistical notes. By Monday, you will be able to view a web cast of this briefing on kaisernetwork.org. You can also view a transcript within a few days and there are copies of materials that you have in your packets on both the kaisernetwork.org website and the Alliance website, allhealth.org. We will let you know when the transcript is available. There is a pod cast you can download. You can wallow in this discussion for the next week and get every little bit of analysis.

We are going to ask you to fill out the green question cards at the appropriate time. There is a microphone here and my eyes cannot see it but I know there are microphones back there that you can use to stand and deliver your question orally at the appropriate time.

So let us get started. Please take a moment to turn your cell phones off so that you will not be distracted and we will not be distracted.

I am pleased to have, representing as I mentioned, the Commonwealth Fund today, the CEO of the Fund, Karen Davis who is one of America's leading health economists. She is co-author

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of the paper and proposal that is the jumping off point for today's discussion. Karen, I will turn it over to you.

KAREN DAVIS: Thank you Ed. It is a real pleasure to partner with the Alliance for Health Reform on a number of activities and particularly to co-host today's session and to have an opportunity to share with you some recent work that was published in Health Affairs called, "Building Blocks of Universal Coverage and Health System." Savings was an accompanying issue brief to that report that I know you have in your packets.

As Ed mentioned, we were established in 1918 to support independent research on healthcare and in particular, to promote the common wheel, the common good. So that is where the Commonwealth comes from.

Today, our mission is very much focused on moving the U.S. toward a high performance health system that simultaneously achieves better access, improved quality, and greater efficiency. There has been a saying for a long time that you can have two of those three but you cannot have all three of access, quality, and improved efficiency but, in fact, our board of directors in 2005, set up a commission on a high performance health system and that is their charge, to come up with ideas that can simultaneously address all three of those issues.

It is chaired by Dr. James Mongan who is President and CEO of the Partners Healthcare System in Boston and has distinguished experts and leaders from across the country.

As the commission has focused on the U.S. healthcare system, it thought the best place to start was just taking stock and it has issued national and state scorecards on health system performance. That score, the U.S. or state health systems not against what is ideal but what has been achieved somewhere for some group of patients, for the most part, that is comparisons within the U.S.

So it is looking for what did the top 10-percent of hospitals do; what did the 10-percent of health plans do; what did the best five states do; and how much could we gain if all of the U.S. were to reach the levels, benchmark levels, of performance of high performing organizations or geographic areas within the U.S.

The commission has since turned to really trying to find strategies that would get us to high performance. One key strategy is improving health insurance coverage and issued a report called “A Road Map to Health Insurance for All: Principles for Reform.” It has set out an overall ambitious agenda for the next President that says it is not enough just to do coverage. One must simultaneously address issues of quality and efficiency in the healthcare system.

To help with that effort, the Commonwealth Fund released a report called “Bending the Curve,” in December of 2007 that features 15 different reform options and has estimates from the Lewin Group of how each of those 15 proposals would affect total health spending over ten years and how it would affect each of the major sectors – the federal budget, state and local government, employers, and households.

So it hopes to move this debate forward. It is not recommending or endorsing any of those particular options but getting them out on the table with some real numbers so that there can be greater focus and discussion of those alternatives.

Certainly I think the conclusion of the commission is that we have lots of opportunity for improvement in the healthcare system. We all know that we are spending 16-percent of the gross domestic product on healthcare. The Medicare program projects that we will go to 20-percent of GDP in the next ten years if we do not alter our current course.

We have also seen, in our international work, that the U.S. is falling further behind other countries on issues like preventable mortality amenable to Medicare. When we did our scorecard, the U.S. was 15th out of 19 countries on that indicator of performance. More recent data published in Health Affairs in January of this year shows that, while we have

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improved, we have improved by four percent. Other countries have improved by 16-percent and we are now 19th out of 19 countries.

So it is important to really get ideas, constructive ideas out on the table, get some discussion, and really look at how we can improve performance across all three of these issues of coverage, quality, and efficiency. And in fact, that is what the work we are here today to discuss tries to do.

Modeling that was done for Building Blocks looks at combining coverage for all with other broad reforms to see what its implications are for the total health system and it also lays a foundation for building coverage, building toward universal coverage for all Americans by preserving the role of the private market but doing so in a way that builds on the strengths on current public programs as well as improving the quality of care.

I think what unites us all in this room and in this city and in this nation is the desire to get the best healthcare for our families and our friends and to do so in a way that gets high value out of the resources that we invest in healthcare.

Certainly a majority of the public agrees with that. I think our presidential candidates agree with that and we really have a historic opportunity with the new administration in 2009

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to make changes to transform our healthcare system and really assure our health and prosperity as a nation going forward. Thank you and with that, I might take the opportunity, if I might, of introducing my colleague and I will leave it to Ed for the rest of the panel to introduce my colleague, Cathy Schoen, who is Senior Vice President for Research and Evaluation at the Commonwealth Fund.

I have mentioned all of this work that we do. That is the royal we. It is often done by Cathy Schoen and people in the audience like Stu Detterman [misspelled?] and Tony Shea [misspelled?], and Sarah Collins and other professional staff at the Commonwealth Fund but Cathy has been the lead author on our national score card, our state score card reports, and is a major resource to the commission and is here today to, as lead author on the Health Care's articles to present this work to you.

CATHY SCHOEN: Thank you Karen. As both Karen and Ed mentioned, you have in your packets the article and when you came in, and I do not know how Alliance staff did it but they matched it to the color of my shirt, a bright pink issue brief and my remarks are going to be summarizing both of those.

What we have laid out in the Health Affairs article and then expanded on in the issue brief is potential building blocks and a framework for expanding insurance to all that

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would offer a new national connector that, for the first time, would have a reformed Medicare-sponsored public plan along with private plans and it would offer it to the under-65 population and I will describe that framework and the estimates that the Lewin Group did on what its potential was in terms of coverage.

We have also looked at what would happen if we had a more integrated health insurance system that it expanded to everyone in the country for a new foundation for insurance and if we coupled it with strategic system reforms, information systems, payment reform, and population health to achieve the triple goal that Karen just discussed of access, quality, and efficiency slowing the growth of health expenditures but with an emphasis on value.

In the building blocks approach, we set up a new national connector and the next slide, I will go through the elements of this that build on the strength of private and group coverage, integrates them, and offers new options for the small group and individual market.

It would achieve near universal coverage covering all but one percent of the population. It would do it by offering new product, a new public sponsored plan as well as private insurance plans much the way Medicare now offers the Medicare Advantage product to those in the over-65 population and the estimates are the efficiencies in terms of administrative

savings as well as building on Medicare's national networks is that it would be able to offer products that are at least 30-percent cheaper than are currently available particularly in the small group and individual market.

There would be new choices that would offer improved coverage for the insured – not as well as covering the uninsured both lower premiums and more comprehensive benefit packages. It offers a framework of moving from where we are now to universal with minimum disruption in where people are. If you like the insurance that you now have, it is working well; there is no need to move. All decisions to move would be voluntary.

The plan, as the estimates of the first year impact from Lewin illustrate, could be done at minimal net national costs with administrative savings offsetting some of the costs of increased use for the uninsured population and if you coupled this insurance approach, this new more integrated foundation with payment reform, with information systems such as HIT and the Center for Comparative Effectiveness, with Population Health initiatives, there is an opportunity to have a system approach that achieves savings for the nation and offsets the federal costs of that insurance expansion.

The core elements of the building blocks framework for insurance start and are organized around a new national

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insurance connector. This connector would offer a reformed Medicare-like option, which we have called Medicare Extra and I want to underscore that this is an integrated plan. You would not need to supplement benefits.

So it is offering a package that looks much like what large employers currently offer now. It has drugs. It has co-payments, but it covers preventive care services in full and it provides a catastrophic cap but that plan would use Medicare's broad network of hospitals and doctors and be available nationally. It would build off Medicare's payment systems with reforms that I will discuss.

We called this Medicare Extra and I will refer to it later throughout as Medicare Extra. It would be coupled with insurance market reform both inside the connector if you came in and took the public option or an array of private options. There would be no questions about what your health status would be. It would be adjusted community rate, with guaranteed issue and external connector to the connector, those same rules would run in the regions where it was operating.

We have coupled that with tax credits that would assure that coverage was affordable. Low-income families, those in the bottom two tax brackets would not have to pay any more than five percent of their incomes for premiums and higher income no

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more than 10-percent. So there is a tax credit for premium subsidies.

We have also expanded the Medicaid program to at least 150-percent of poverty for adults and childless adults. States could, at their option, go higher and within Medicaid, we have asked Lewin to model Medicaid's prices coming up to Medicare to avoid the disadvantage Medicare recipients now face \in markets.

We require everyone to have insurance within that framework. So there would be an individual mandate accompanied with these tax credits for affordability and expanded options and employers would either need to provide coverage or pay into an insurance fund as part of the support for the expansion.

Within Medicare itself, we have eliminated the two-year waiting period for the disabled, allow early buy-in. Employers and individuals could buy into Medicare early at an actuarial premium for those aged 60 or older.

We also would offer the Medicare Extra benefit package as a supplemental package to the Medicare beneficiaries so they could, for the first time if they wanted to, have one integrated package rather than having to carry three insurance cards if they now want to sub Medicare and drugs.

This illustrates what the estimates are that would happen if one set up this type of framework, these building

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blocks. Almost everyone would get coverage. We would be covering 44 million out of the estimated 48 million uninsured. You would be automatically enrolled through the tax system. So the people we missed would be mainly the non-tax filers.

The flows of the uninsured would both be going into private coverage. Some employers would be offering, for the first time. Some would go into Medicaid and many would go into the new connector, which would be open to anyone in the individual market as well as the small group market, employers under 100.

As you can see from the arrows, there is also a flow of movement from the currently insured. We estimate as many as 50 million, 49 million would move to new sources of coverage including into this new national connector, which would pick up about 60 million people, two-thirds of which would be in the new publicly sponsored Medicare Extra option but the others would be in private group plans.

So this is a new competitive dynamic that would be set up both inside the connector and external that you would have a choice of staying and purchasing directly through private markets as many employers do now or if you were a small employer, individual coming into the new connector, similar to what Massachusetts has done in the connector concept, only this

would be run nationally and it could be run through regional operations.

What that ends up doing in terms of the distribution of coverage, we leave most of the employer-sponsored base in tact although some employers would now be purchasing through the connector. The new connector picks up a large share of the uninsured as well as the individual and small group market and Medicaid stays about the same. Some Medicaid beneficiaries end up moving into the connector, moving into their employer coverage and remember, those circles are all choices so there is the ability to move voluntary through those different sources of coverage and sponsorship.

Turning to what could happen if we take that approach and that approach alone could be done with minimal national cost. The estimates are only $15 billion in national costs off a two trillion dollar base with coverage alone. There would be federal costs.

If you coupled it with payment reform, starting to pay for medical homes, better enhanced primary care, more bundled episodes of care payments, and reforms that spread across the Medicare population both current and through the connector.

If you coupled it with those proposals plus HIT, we could get a fully implemented HIT system, health information

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technology, and a new center for information about comparative effectiveness and public health initiatives.

We estimate, if you look at ten years, that there would be net national savings that would accumulate over time building by the tenth year of at least 1.6 trillion dollar and this, as you can see in each year, is a small accumulation but starting from a two trillion base, which is expected to go to four trillion, these savings add up quickly.

The savings for the federal government would offset the cost of coverage expansions. So the initial expansions, if they were done just alone in coverage would not be self-financed but savings could self-finance them. We would bend the cost curve compared to where it currently is substantially with better access, better quality, and efficiency.

To sum up this approach is trying to take a systems approach that starts with the basic goal of achieving coverage for everyone but in an integrated way so there is a more secure insurance foundation with the leverage for payment reforms and other reforms.

The potential for a new competitive dynamic, if we take a systems approach, we can get coverage with value but I want to end with just one statement that this requires political will. It would not be easy to do it.

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The sooner we act the better both for families, businesses, and public sector but it takes new systems put in place, a new way of thinking about insurance in a more integrated approach. Thank you very much.

ED HOWARD, J.D.: Thanks Cathy. It is a very sound foundation for the rest of the discussion today. We do not often have, on Alliance programs, members of Congress gracing our podium. So we are particularly pleased to have Congressman Tom Price Georgia with us here today. He has been among the most active members of Congress on health issues. He is, for example, the main co-sponsor in the House of bipartisan legislation that would give states the chance to pursue a whole range of reforms to broaden coverage and contain costs.

He also happens to be an orthopedic surgeon and has some first hand experience with the Medicare program in that regard. His opinion piece from the Hill on today's topic is in your packets. We are delighted to have him on the panel today. Congressman Price?

REP. TOM PRICE (R-GA.): Thank you Ed very much and after my presentation, you may see why they do not normally have members of the Congress on the panel. We will see. I want to sincerely thank the Commonwealth and the Alliance for hosting this and for allowing me to join you today and I guess

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the first question would be why am I here? Ed pretty much summarized it.

I spent 20 plus years in the practice of medicine and have appreciated, I think, first hand the consequences of the decisions that are made in these halls and the buildings around us here in Washington as how it relates to on the ground, in the clinic room, in the operating room, and what those consequences are.

So I have a passion. I share a passion with my friends here on the panel for health system reform, fundamental health system reform, and I am excited as ell by the prospects of the presidential election and the true contrast in choices that I think that we will have.

I titled my vision for healthcare, of patient-centered healthcare. I think oftentimes when we talk about health care; we lose sight of the fact that what we are talking about is patients. When you think about that, we are talking about you. We are talking about you. We are talking about me.

Every individual who exists in our nation has at some point had some health challenge. Sometimes they are major and sometimes they are minor but it is a very personal, personal system. It is a very personal question that we are asking when we talk about healthcare.

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So I entitled my vision of Patient-Centered Healthcare" and I believe we are at a crossroads for a variety of reasons, some of which have been outlined but demographics and cost and the like.

What are we looking for in patient-centered healthcare? This is no different than what any of us up here would describe or anybody who has any vision or passion about healthcare, we are interested in a system that is affordable. We are interested in a system that is accessible by individuals. We are interested in one that is response.

One might ask who should the system be responsive too. I would suggest it needs to be responsive to patients, not necessarily those that are devising the system. It needs to be innovative. We need to make certain that we continue to have the greatest healthcare in the world and it needs to be of the highest quality.

What is Medicare? I would suggest to you that it is none of those things, that Medicare is none of those things and consequently the question being asked – should Medicare be the model for reform?

Obviously my recommendation to you is that it not be the model for reform and we will go through some of the reasons why. Medicare is not affordable. It is clearly not affordable either from a standpoint of cost or I would suggest it is not

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affordable from a standpoint of options that patients have. It is not accessible. Twenty-five percent of physicians across this nation now limit the number of Medicare patients that they see.

The Mayo Clinic is now limiting the number of Medicare patients that it is sees – the Mayo Clinic. If that is happening, you know that the system is about to implode on its own weight. It is not responsive. It took us 40 years to get Medicare to see that they needed to have a prescription drug program within its confines.

So it obviously is not responsive to patient – not innovative, not on the cutting edge in anything and it is not because of its structure. It only pays for things that it says that it will pay for. You cannot pay for innovation if you do not have a code that responds for innovation. It is not of the highest quality and I would suggest it is not because it is not all of the things above.

So is Medicare the model for reform? I would hope not. I think we are brighter and better than the system that we currently have. I would also suggest to you that the current system that we have has used Medicare as a model. You know that private insurance, right now, essentially tracks Medicare for reimbursement and for coding and all those kinds of things and

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consequently, Medicare is essentially the model that we have for the system that we currently have.

So we are at a crossroads. Are we going to go more in the direction of individuals in this city and buildings around here deciding where healthcare goes or are we going to let doctors and patients determine the direction for healthcare? When I was in the operating room, I never asked this question or made this statement but I probably should have given the consequences of what has occurred.

What about Medicare? What is a fundamental reason why it ought not be trusted? Well it is not trustworthy and it is not reliable and it is not because the people in the system are bad. It is not because Ms. Wilensky and others in CMS previously and now are bad. It is that they have a different mission. Their mission is to make the bottom line meet. It is not to be responsive to patients and so when your mission is the bottom line, then that is what happens. That is what you pay attention to. It is not reliable.

I would suggest this comes from the original bill that authorized Medicare. Nothing in this title shall be construed to authorize any federal officer, employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided. That is still on the books today. That is still the law of the land.

I would suggest to you that anybody who has an appreciation for healthcare understands that – that has been violated multiple times. I see my clock is not working, Ed, and I appreciate that. I am moving on through.

ED HOWARD, J.D.: Your eight minutes is eternal.

REP. TOM PRICE (R-GA.): What about the sources of healthcare spending? You see a significant change over the last 45 years. You see there the consumer payments in 1960 were about 50-percent. In 2005, government funds were about 50-percent. You all know the golden rule. He who has the gold makes the rules.

Historical gap between the estimates for costs for healthcare in this nation and what they actually are. In 1965, it was estimated that in 1990, Medicare would cost nine billion dollars. In inflation-adjusted dollars in 1990, it actually cost 67 billion. Medicare spending today is 450 billion.

Now it is important to point out that nine and 67 were for part A and that 450 is the whole shebang but you can appreciate that the estimates for what Medicare costs have been less than accurate.

Rising costs of healthcare – this goes back to 1960. It is the per capita costs and it goes from about $1,000 all the way up to 6,000, a little more than 6,000. Costs continue to increase without a doubt.

So how do we solve this problem? I would suggest that there are two pillars upon which we need to build a positive patient-centered reform. One is universal coverage and I do not know that you will find a whole lot of conservatives who will stand up and say that you absolutely must have universal coverage but we have got to have universal coverage. You cannot have a system where there are 45, 46, 47 million people episodically uninsured at some point during the year and not and have the system work.

The second pillar is a defined contribution mechanism. Universal coverage – how do you get there if you are not going to have an individual mandate or an employer mandate or a pay for play, pay or play.

Tax credits – we use the tax system to incentivize and make it so that every individual in this nation, it would be financially wise for them to gain health insurance and financially foolish not to have it. You can do that through a variety of mechanisms – deductions, credits, refundable tax credits, advanceable refundable tax credits, tax equity for the purchase of insurance, various pooling mechanisms that exist now and other more dynamic mechanisms.

The second pillar – define contribution. What does that mean? It means that patients own and control their health insurance. They own and control their health insurance. So when

they call up the insurance company or the federal government, the individual on the other end of the line says how may I help you instead of what do you not call somebody who cares? Because right now, patients do not have power. They do not have any power in this system.

How do you get the system to move in the direction that we want it to move? Hopefully we all want it to move in the direction that patients want it to move. The only way to do that is to empower patients. I would suggest to you that the only way that you empower patients is to allow them to have control over their health insurance policy and make it financially feasible and advisable that every patients, every individual in this nation have health insurance. I am privileged to be on the panel. I look forward to your questions and look forward to the discussion of the others. Thank you so much.

ED HOWARD, J.D.: Thank you very much Mr. Price. By the way, we did not get these slides in time to put them in your packets but we will make them available on our website shortly after the briefing.

Next, we are going to hear from Steve Lieberman whose mastery of healthcare numbers is legend in this town. He has been head of the health staff at CBO. He has been a senior staff member at OMB. He played a key role at CMS in

implementing the new drug benefit in 2004 and he is now a consultant to a number of groups on a range of healthcare policy topics, mostly quantitative in nature but not exclusively, and we are very pleased to have your skills brought to this panel. Steve?

STEVE LIEBERMAN: Thank you very much Ed. If anyone has difficulty in the back, let me know please. It is a pleasure to be here. I wanted to thank Ed and the Alliance for organizing this session and particularly want to acknowledge the contribution of Cathy, Karen, and their colleagues at Commonwealth not just for the article, the Building Blocks article, which I think is extremely impressive and an important piece, but for their work over the last several, many years but the last several years in particular on this topic.

Unfortunately my role today is not to focus on how full the glass is but rather on the parts of the glass that are still empty but I do want to explicitly acknowledge, I think, the importance of their contribution and the difficulty of trying to move in what I think is a very intelligent way, which is to deal with incremental reform but to try to keep all of the pieces that are part of our complex health system in mind and try to address them.

Today, I will quickly go through three main topics I will try to first give a high level assessment of the Building

Block proposal. I will then second try to focus on the fiscal pressures that we face and particularly those associated with excessive growth and healthcare costs as Representative Price has described and I then want to focus on some of the key choices that I think we will frame as we think about the policy debate.

ED HOWARD, J.D.: You might try to get a little closer.

STEVE LIEBERMAN: Okay. Thank you. Is this better for the background?

So I am not going to go over what I list in these slides, some of the key open issues but I do want to just highlight a couple of them. I worry over time about whether costs and revenues are balanced. I worry about whether we have adequate mechanisms for controlling the rate of increase and cost, and I also worry about how we would have private plans that are at risk operate side by side with governmental plans that are not at risk, and particularly whether we set up some significant selection issues.

The second think I would like to make a comment on in terms of the Building Block proposal is again, I want to compliment Cathy and Karen and their colleagues for including a cost estimate but I want to observe from my think if I could put on my CBO perspective that it is simply not credible from the CBO perspective at this point.

There may be further details, John Shields [misspelled?] and the Lewin folks are experienced estimators but, at this point based on what I have seen, I just want to highlight couple of things.

First there are savings that are assumed from, I believe, unproven approaches and to some extent on specified approaches.

Second, I think the Medicare expansion, as I understand it, looks to be quite costly and I am not sure I see adequate offsets for those costs.

Third, I worry about the longer range imbalance. If costs are essentially the costs of the program, the subsidies are harnessed to the increasing costs of healthcare and we have not been able to succeed in bending that cost curve down that has, I think, pretty dire fiscal implications and finally, I worry about whether the tax rate is adequate.

The next two slides, this one comes from recent data released from CBO in an issue brief and the next slide, which is in your packet, is actually the slide that I just literally lifted from CBO.

The green line here represents Medicare and Medicaid spending. As a share of the economy, it will more than double over the next 25 years from four percent of the economy to nine percent of the economy.

This slide, which I apologize, is being rather busy, but I will blame CBO for that. The blue area, light blue is Medicare and Medicaid spending. Clearly what this shows is that we, as a society, have promised a lot more in the way of benefits and particularly benefits for the elderly and disabled than we have historically been willing to tax ourselves. That is not to say that the revenue line is immutable but it is the post-war experience.

The key part to keep in mind in thinking about what I think is a pretty dismal long range fiscal outlook is CBO has already assumed and a significant decrease in what we have observed historically is the rate of increase in what is called an excess healthcare cost, which is the extent to which healthcare costs are growing faster than per capita GDP.

CBO is assuming that Medicare costs, over the next 75 years, will go up 1.7-percent. Medicaid costs will go up less than one percent, which is a substantial improvement from what we have seen in the past and the other interesting point to note is CBO comments that most of the increase in healthcare in Medicare, Medicaid spending increases are associated with rising costs per beneficiary not increasing numbers of beneficiaries nor with the aging of the population. So my point here is what we do to control the rate of excess healthcare cost growth is to key to what we can afford.

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I want to turn now to briefly go through what I think are some of the key issues that a proposal such as the Building Blocks proposal poses and hopefully ones that are irrelevant to the policy debate.

I think the first order question is whether Part D of Medicare, which is a competitively bid system for prescription drugs, whether that is a viable model for a more comprehensive health plan and currently, I would argue Part D has vigorously competing at-risk plans.

There are very strong price signals that are set to the way the premiums are set and the bidding mechanism works. Beneficiaries seem to be responding to those plans and price signals and lastly, and I think this is quite an important point, CMS I think has shown that it was actually capable of implementing the system and putting out a regulatory framework, which essentially is more akin to a regulation at a wholesale level structuring the market rather than very detailed rules setting up complex payment systems.

The other choice for Medicare, and I think Cybele is likely to talk more about this, is a more classic fee-for-service approach, clearly the Building Block proposal assumes both.

The question I would pose about this is whether fee-for-service is viable from a number of perspectives as we

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increase by tens of millions of beneficiaries and the share of healthcare dollars that are being controlled by Medicare - the sheer complexity and information requirements of what are extraordinarily complex payment systems and the need to get literally tens of thousands of relative prices right and if you do not, there can be significant distortions, I think, is a real question in the ability to CMS or literally anyone to get that right is a real significant issue.

Even if CMS or whoever we are administering this program got it right, the question is whether that can stand political scrutiny, whether the combination of interest groups and congressional intervention would let what would appear to be if you were to accept this – technically the best solution – to stay in place or whether we get further distortions.

There clearly are other key choices and as Cathy mentioned, investments in health information technology, electronic medical records, public health, comparative effectiveness, those are things that are quite likely, over time, to improve health and healthcare. The question is whether they save money.

At this point, there is very scant evidence of any that they save money. They may be good things but the point here is we know an awful lot more about how to spend money and increase

our costs and we have great uncertainty about how to control costs and reduce costs.

Similarly on that vein, we know to expand coverage. We know how to enrich subsidies. We know how to make programs more generous. The key question and, I think, the key uncertainty is our ability to not spend more but to control the rate of spending and in particular, the question of affordability goes back to being able to control the rate of healthcare costs. With that, let me quickly conclude by making four quick observations.

The first, I want to go back and explicitly say, I think this is a really important piece. It tries to deal in a comprehensive way with what normally does not go in the word with comprehensive, which is thinking about incremental changes and try to keep all the balls being juggled.

That said, from my perspective, there are still open issues. That is not to say these are disqualifying issues, just ones that need further work. My other concern is I do not believe, at this point at least from the CBO perspective, the costs add up.

Clearly a critical piece is the ability to lower how much actual healthcare costs grow and to some extent, even though the fiscal picture is somewhat dismal, CBO has already made some optimistic assumptions about what will happen in the

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future and I would just caution, we are historically better at spending money than figuring out how to control the rate of increase.

The conclusion that is a personal judgment and it is a clearly a key judgment that other people could easily disagree with is that I think that Part D, as a bidding approach, is a more viable, more promising approach in adding to fee-for-service. But the last point that I want to make with which I would hope no one on this panel or in this room would disagree, is that we literally need to increase the resources and capability of the federal government.

With all due respect to my former colleagues at CMS who I think do an extraordinarily good job, they are under resourced and the challenges they face exceed their capacity to deal with them under the current system. If we are going to put more emphasis, more weight, new initiatives, I think we need to be very serious about providing the infrastructure that is required. I look forward to our discussion. Thank you.

ED HOWARD, J.D.: Great Steve. Thanks very much. Now let us move to Cybele Bjorklund on my far right. I love to say that. Cybele is the Staff Director for the Ways and Means Subcommittee. She has served over here on the Senate side both with Senator Kennedy and Senator Daschle.

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She has been a Medicare analyst at what is now CMS. She is one of the few people on the Hill who embody the kind of institutional memory of Congress on health policy issues. So she is going to be a very valuable asset to the folks in the Ways and Means Committee and in the House over the next few months and I am pleased to say, she has graced a number of Alliance programs over the years. Cybele, thanks for joining us. We look forward to your comments.

CYBELE BJORKLUND: Thank you Ed and thank you Karen for all the work you do on this and getting us here today. Gail Wilenski and [inaudible] to the right of me too.

Ominous. Pushing even further right. Does this one work? Yes. Okay.

I keep thinking one of these times I will actually do a PowerPoint presentation but I never manage to do it so you do not have to see that. It also means I have to read my notes, which means I am not quite sure what I will say because my writing is notoriously bad.

I will say this is a tremendously important topic. I think it is very timely and we were thrilled when the Alliance and Commonwealth Fund decided to move forward with this. I think the turnout here is fantastic. There is a lot going on right now and to see everybody here to discuss this right now, I think, is really wonderful.

I think there are a lot of issues, I think, that will start being discussed more as we move forward, obviously, toward the presidential and next year and the hope certainly from Democrats is that health reform will become front and center, the most domestic issue that we will start dealing with and certainly, in our committee, we have begun a series of reform hearings mostly around issues laying the groundwork not talking about solutions yet.

I know finance is doing the same. I think energy and commerce is going to be moving forward. Help is staffing up and there is really a level of excitement and anticipation that we hope there will be some forward movement on this front next year.

To that end, I think even from the Ways and Means perspective where we also have jurisdiction over tax, trade, other issues like that, not only is it a moral imperative that we are sort of the last industrialized, civilized nation to not cover all of our people. It is also an issue from a competitive standpoint with respect to our businesses here and abroad.

When you look at the disparities that are developing between businesses that offer and do not offer here, the ones that do come to us quietly and say it is not fair I am getting killed by health costs and the ones who are competing globally, you need only look at the autos and the differential costs

between Canada and here where the fact that we pay more for healthcare than for steel to know that this is hurting us and hurting our sectors in terms of how we go.

So moving forward, I would say there are a whole lot of different ways to go about it. I would think that Democrats are at large, not that I could speak for any beyond my bosses, will in any event be looking though at combination approaches that people want to build on what works.

I think that is one of the wonderful things with the Building Blocks proposal and other ones and really be looking at sort of combination of shoring up what is out there today as well as using public program expansions and other ways to make sure that people who do not have coverage through the work or elsewhere have a viable place to go.

Chairman Stark, I work for Chairman Rangel [misspelled?] and subcommittee Chairman, Chairman Stark and Stark is fond of saying look, our three broad-brush goals are that everybody be covered, that providers and other people in the system be making a reasonable income. He is always quick to add it may not be desirable but a reasonable income and three, that everybody is in and paying according to their ability.

For him and I think for Chairman Rangel as well and a good number of democrats, Medicare may have its warts but it is far preferable to what we have seen on private insurance on

many fronts in terms of its efficiency, its effectiveness, and its equity and for that reason, for us it is often the first place we look when we are looking for a public program expansion.

It does not have the variability of the state-based approaches. I has got the ultimate sort of inflexibility, in many ways, around the fee-for-service side of the program – what you are doing. We can talk about some of the other warts in a moment.

So Stark's main bill that he is pushing right now is a bill called AmeriCare, which Commonwealth, last year, evaluated a number of the leading congressional proposals - AmeriCare, the Widen Bill, Bush Tax Credits, AHPs, and other small business plans and out of all of those, found that AmeriCare ranked the highest in terms of its ability to actually cover people, its ability to control costs, and sort of its again, overall effectiveness of where it was going to go.

In AmeriCare, we encourage employer-sponsored insurance. We do not believe in sort of tearing that down and starting over. That is too much instability for 170 million Americans. So we encourage it but then we create a Medicare buy-in for people who do not have employer-sponsored insurance and there are additional subsidies for low-income.

Medicare buy-in is not a buy-in to Medicare proper as it exists right now. There are modifications to the benefit package to make sure, for example, that there is proper benefits for children and more prevention are other things. We include some of the things that Steve has mentioned in terms of being a critical element of a system, health IT, comparative effectiveness, things like that but there is really – it is a pretty straightforward approach to where you could go here.

Now, in fact, you would also see the recent – Ed invited me to be here on behalf of the committee – variations on a theme. For many years, basically since the creation of CHIP, Chairman Stark and Senator Rockefeller have introduced a bill called Medi-kids, which takes a similar kind of approach to insure children. So the notion was if we were going to start with children, they took a bill.

They did this with the enthusiastic support of the American Academy of Pediatrics and the Children's Defense Fund and basically said every child would leave the hospital upon birth with insurance and the gist of it is if you could show that you have insurance already then you are fine.

If you cannot show it, you are automatically enrolled in this program and it comes off of your parents' taxes the following year until and unless they can show they have other

coverage for you – again with a modified benefit package and this is oversimplified but this is getting to the gist of it.

The other thing that we have looked at a lot, sort of since the late 90s, and continue to talk about is a Medicare buy-in for the under-65 near elderly. So whether you would say 55 to 64 or 60 to 64, basically looking at this population next to children's, it is fast growing and it is intractable. It is very difficult to insure. If you reached that age, you almost certainly have pre-existing conditions.

The private market is not working well for these folks and they are going to be aging into Medicare anyway. So why not give them an opportunity to buy-in early. There are all sorts of levers you can do around that whether you subsidize or do not subsidize. It is simply an option whether you have the employers be able to buy-in their early retirees. So there are a host of policy decisions but it makes a lot of sense considering they were going to get there at some point.

A key data point that came out recently that we find very compelling on this is again in this cohort, which is very difficult to insure through the current private market, what we found is people entering Medicare previously uninsured are costing the program a lot more. There is pent-up demand and anxiety coming in with poor health status and it is a material cost to the program.

So if people needed additional reasons to look at this as a population that needs extra help that is one more point from our Medicare perspective where we need it.

I should note too that most of these programs, when we looked at them, we do them in a way that walls them off from the rest of Medicare. So to the extent people are worried about the financial challenges facing Medicare now, we need to be looking at those and addressing those.

Creating these additional buy-ins can be done in a way that does not harm the program and indeed it could help the program if you are keeping people healthy when they get on there or looking at other cross-subsidies that the risk pools turn out differently.

I think in sum we believe, contrary to what some folks think, that Medicare has been a tremendously effective and popular program among beneficiaries, American families, and despite rousing by a number of providers, most of them tell us categorically when asked, that they prefer Medicare to the private insurers in terms of both reimbursement and management.

So many of the things that critics of Medicare blame on the program in terms of its benefit package not being fully modernized, really need to be laid at the feet of Congress, that we have set up the program in a way that we need to be the ones to act to make improvements in it.

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So on the prescription drug front, there were efforts in the early to mid 70s by Senator Kennedy and others to add prescription drugs then. It just simply took us 20-30 years to do it because of political opposition in some camps and some of the special interest concerns.

So there are other avenues, I will say, prevention. There has been a lot of talk in the last ten years about modernize the program with prevention and we did some of that in the BBA and we, in the Champ act last year on the House side, went ahead and said let us give the Secretary the authority to modernize the program without us.

Let us cut ourselves out of the equation and say Mr. Secretary, you may add these preventive benefits if the Preventive Services Taskforce or other people think that they are wise for this population, add them without us. Let us waive the cost sharing for it because last we looked, we do not have a problem with too many colonoscopies here and it does not cost very much to do that.

Yet, in the language that we are going to be considering this year, because of ideological concerns really from folks who do not want to improve the program at all, they do not want to do it. I think they would prefer to still come out and say that it is a 1965 program, that it is stuck, that we cannot move forward.

So it is very, very difficult to make some of those changes but I guarantee if everybody were in, there would be an even more vested interest in making things work as they should.

So with that, I will say we believe the keys for reform are finding a program that is available, accessible, affordable for all; that it is portable and easily administratable, and we think that Medicare fits that bill. The administration stuff I will not gloss over as being easy.

I think Gail will address that but where there is a will, there is a way and this, to us, seems to be working a lot better than the private market. The private market would need tremendous regulation that I do not think they would want to endure to really work for all Americans. Thank you.

ED HOWARD, J.D.: Thanks very much Cybele. We are going to turn now to Gail Wilensky. She is an economist. She is a Senior Fellow at Project HOPE. She also probably understands Medicare and health insurance as well as anybody in the field. She has been the Chair of the Medicare Payment Advisory Commission.

She has actually run Medicare when she was Administrator of what is now CMS. She has looked at a whole lot of Medicare-related proposals over the years and we are very pleased that you have accepted our invitation to share your thoughts about the ones we have been hearing today. Gail?

GAIL WILENSKY: Thank you. Is this on? Okay. Yes, I do really love the notion that I have Cybele to my right, now my far right. Earlier I was late, excuse me for coming in late but I was speaking at Medicaid Congress, my other hat that I frequently wear.

I was asked to comment about the administrative issues that the proposal raises and I am going to start there but I had a couple of other observations that I want to offer as well.

When you look at the Building Block notion and I hope you will forgive me in saying this, I actually liked the earlier version slightly better but it is really a values question of how you want to move forward in terms of extending coverage to the population without coverage and I honestly think that really is the answer more than could CMS be able or a CMS-like agency able to run this. I think the answer is yes, it could run this if it were provided with the support structure that it would need in order to do that.

So my bottom line advice is I do not think this is beyond the capability of the agency to do if it had proper funding and expansion. I think it has shown an ability to be quite responsive in what has frequently been a very stressful environment - when asked to implement a very large number of

changes in the existing Medicare program, such has happened after the Balanced Budget Act in 1997.

And when it was asked to do something very different, which was to implement the Part D Medicare, which was an entirely different kind of mechanism, showed an ability to do so – not that there were not problems that resulted in the rollout, the education campaign, and some of the early parts of the administration, for example, of Part D but all in all, it seems to me when you look at how that program rolled out, it was pretty good. By the second year, it was quite good.

So I do not think the argument against this kind of a proposal ought to be it is asking an agency to just do something it could not do properly funded. I do think the issue about whether or not CMS has been properly funded in the past to do what it has done is a very legitimate one.

I have signed on early on with a bunch of signatories now and I cannot remember which year that Congress should not keep asking the agency to do more and more without providing a commensurate level of support for the administration of these programs. It is just asking for really bad things to happen.

I think one of the fundamental changes that needs to happen if this is going to be a serious concept is that we have to move away from the separation where the benefits are funded

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as an entitlement and the administrative support comes out of the discretionary budget, a completely different committee.

Now for many reasons, my plea is to do something to modify both pieces, that is I think one of the very serious problems that we have in Medicare, which has an unfunded liability that is somewhere, I think, the number was $36 trillion, it was a very big number, that we might want to change the budgeting process where the Congress is forced to review what it is going to do about the entitlement part on a periodic basis. There are a number of Republican and Democratic analysts that have come out saying that kind of notion.

Similarly in the same kind of vein, it is unreasonable to fund the administrative part of CMS out of a budget that is going to be directly competing for support for LIHEAP, the low-income support for elderly for their fuel or for funding some of the various supports for low-income populations or education or whatever. I mean that is just doomed to always undercutting the support that the program needs. So if this is going to be a serious kind of proposal, you have to get around that.

I think we may be able to look at what happens to Massachusetts as that folds out to see what kind of administrative burdens and what kind of individuals are needed, how costly it is, where the stresses are. There are already

some interesting learning experiences coming out of Massachusetts.

It is a really good idea to have a better count of your uninsured before you start in terms of being able to know what you are going to spend and that is not a swipe really of saying other than if you get the count wrong, do not be surprised if you get the money wrong. There are a lot of other related issues that this kind of a proposal would result in.

I do want to caution that we need to remember Medicare, by and large, is suffering from the same kinds of stresses as the rest of the healthcare system minus the problem with regard to the uninsured and that we need to focus as much or more on what we are going to do to slow down the spending growth rate in healthcare and to improve quality and clinical outcomes and patient safety

And although it is always tempting, during election cycle, to equate healthcare reform primarily, not exclusively but primarily with expansion coverage – please, please remember that these other issues affect the 85-percent of us with coverage as well as the 15-percent of us without coverage.

In this vein, Medicare does not really look a whole lot better than the rest of the healthcare system and in large part because it is even more reliant on traditional fee-for-service, which as I do not have to tell the Commonwealth Fund, it is

investing a lot of resources in trying to help design a more accountable and responsive healthcare delivery system.

So the one sort of amusing part that I felt, reading through the document, is all the glorification of Medicare, the last bastion of primarily a la carte fee-for-service siloed medicine and we surely do not want to really go forward with that if we do not have to.

I know there was an option for an integrated delivery system. I saw that but I think we might want to get a little more serious about how, if we are going to use this, which is going to clearly cost a lot of money, I do not believe Lewin estimates for a moment.

I cannot echo strongly enough what Steve had said – these numbers are not credible but whatever it is, we need to wrap our arms around these other issues and figure out how we are going to make them as much a part of what we do.

I think the buy-in for near elderly is not such an unreasonable idea as a near elderly person myself although I happen to fortunately have health insurance but we have to decide is this going to be actuarially fair and if so, is it going to be subsidized and if so for whom and how financed.

And oh yes, do not forget the $36 trillion unfunded liability for the rest of Medicare. Be very careful about

giving too much more to put on this program that we do not know how we are going to pay for.

So interesting – people want to throw darts at it. There are lots of places to throw darts at but I would say do not hang your hat on that CMS canned administrate. If given the proper tools, I do not think that is a problem. Thank you.

ED HOWARD, J.D.: That is terrific. Thank you. this has been, so far, even so far without any Q&A and exchange, a terrific discussion. I would invite you now to repair to the microphones to ask questions if you would like. Pull out those green question cards and let me just mention in passing, there is also a blue evaluation form in your packets that I would urge you to pull out and begin to fill out as we start this part of the program so that we can make these programs better for you as we go along.

I would also invite our panelists, if you have some pressing point that you would like to make in response to something that you have heard, you should feel free to indicate that and we will try to accommodate it. Meanwhile we have a questioner who will identify himself and direct the question to somebody if you would like.

MICHAEL GLUCK: Michael Gluck [misspelled?]. I am an independent health policy consultant at the moment and my question builds on, in part on Gail's suggestions about what to

do about the administrative capacity of Medicare in general and as they think about expansions but it is really broader and over the years, I have been impressed with the consistency of attitudinal research that has really documented the public acceptance and support of some of the fundamental values that underlay Medicare.

It is a universality – the notion of intergenerational economic benefits in the financing of healthcare, protection of choice of providers, broadbased financing, those sorts of things and yet, at the same time, we are living with a tremendous skepticism about the capacity of government and some of the ideas that, the critique that was embodied in Congressman Price's remarks about the potential effect of government policies on the practice of healthcare.

So my question is sort of just generally, if we were to go down this path, how important is that barrier, that skepticism and concern, and how do we overcome it and that really is directed at anyone on the panel.

ED HOWARD, J.D.: Okay. Far right, far left?

CATHY SCHOEN: I will just try to give a – it is such a large question. I think confronting potential new way of approaching insurance. We have one state, the state of Massachusetts who has set up something that has never existed before.

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It is quasi-public so you could say it is quasi-private but their connector was funded with an upfront administrative to get it up and running and it now runs off an administrative fee. So Gail's point of self-financing the running of it, I think government can do very creative things and we have seen Medicare do it in the past.

What we need to have is a will to say there is something both in the private sector and in the public sector that we all could gain from if we can envision a different way of approaching some of these problems. So I think it is just we are able to take leaps forward. We could do it but we do not yet have a consensus of what is going to bind us together.

GAIL WILENSKY: I mean I think there is really not the consensus for the non-poor or the, at least above the middle class in terms of how and what and who finances the expansion – not the issue that people should not have health insurance coverage. I mean I think there is a widespread belief that that is there.

So the notion of how you try to create a support for a particular policy is very important and it is why seeing what happened in Massachusetts, it is the applauding the efforts of Widen and Bennett.

I mean I and most other people have looked at it, have a lot of comments, areas that they find or may find

objectionable but it represents an attempt to try to build a coalition that comes out of the middle to see whether or not you cannot be responsive to an issue and that, to me, is really the most serious challenge and it is particularly gets challenging because we are about to go for the next six months into how many grenades can we lob at each other.

Then the election will be over. There will be a two-month hiatus and people are supposed to go make nice and solve these very difficult issues that require a real sense of willingness to give and take in order to solve a problem and, by the way, come up with some substantial amount of money, which is not obvious.

Some of us are somewhat dubious about where the big dollar part of healthcare reform comes from in terms of how to start this process. Those are different kinds of questions, I mean, to ask. There is not the easy answer on how do you try to create that kind of environment other than the sense either one side is so dominating.

The political structure, which is 65 or 70-percent dominant, in at least the Senate as you need to get over those 60 votes and the White House that you do not really have to build a coalition and any other time. I mean that is called Medicare and Medicaid’s passage in 1965 but I do not think that is going to happen.

So it means getting serious about putting a coalition together that really can create support for something – something for everybody to hate and something for everybody to love but enough sense that this would move us forward and actually, Part D Medicare fits that description as well.

It was as good as was going to come out of the Congress in the period of 2000 and 2008 and with a lot of effort and push at the last minute, went over and people can debate whether at the end of the day, they were better off or worst off or not but I mean those are the kinds of issues that we will have to decide going forward.

ED HOWARD, J.D.: Yes, in the back?

JOANN LYNN: Hi. I had two ideas that I would be, I am sorry, I am Joann Lynn [misspelled?] and I am a geriatrician and health services researcher and two ideas that would be fun to hear you all bat around.

First is that if we are serious about patient-centered priorities and everybody seems to claim to be serious about that, when we are old and sick and frail and ill on an every day basis for a few years, our priorities are not those of the current Medicare program.

Our priorities are much more pace-like, continuity, comprehensiveness, supportive services, never getting a pressure ulcer, never having a fall, and much less high-tech

interventions and whiz bang gizmos from me and my medical partners.

If we were building a care system that was actually responsive to the needs of patients then the current Medicare program is actually better suited to the near elderly than it is to a large proportion of the elderly and it would seem that we could take the opportunity to begin to notice that and make the financing match a delivery system that is actually accommodating to the needs of people who are terribly disabled, living for a substantial period of time ahead of death.

So that is one idea is whether we could take the current round of debate as an opportunity to begin to segment Medicare rather than thinking of it as one population.

A second is that if we wanted to cover the near elderly, we might be able to use some wisdom from some other countries and notice that we also have an enormous shortfall in direct care giving and that we are pretty much out there alone as a country that provides almost no support to family and voluntary care giving.

If we, maybe as a first step, maybe as the only step, started to tie coverage to providing care giving, we might add the sense that these are especially meritorious beneficiaries. So if you said, for example, people 55 to 65 who are providing more than 40 hours of week of care to a Medicare beneficiary

would be eligible for Medicare coverage if they have no other way of getting covered.

Once upon a time, about ten years ago, we costed that out as a rough estimate. At that time, it was only about $250 million. I mean it is spare change in the federal budget but it would begin to have us examine what happens when you expand Medicare and can we handle it for an especially meritorious group of people whose work actually helps reduce the costs in Medicare.

ED HOWARD, J.D.: Interesting ideas and not surprisingly Joann. Response from any of the panelists? Price?

REP. TOM PRICE (R-GA.): I would be pleased to comment because I think that they are excellent observations and I would suggests that as you said in your opening sentence or two, it is a lack of responsiveness of the current system and that is because the current system is responsive to the individuals that are driving it and the people that are driving it are not patients.

So we do not have a system that is responsive to geriatric patients. We do not have a system that is responsive to caregivers because patients are not driving the system. If in fact, we were concerned about a patient-centered system and having a system that were responsive to patients, the only way for a system to respond to patients is if patients have power.

The only way I believe for them to have power is to have them own their health insurance policy regardless of who is paying.

That is why I believe that the pillars that I outlined are the ones that get us to the point that we want to get because as my son, who is 18 years old, the last thing he is thinking about right now is health insurance but as you talk about your geriatric patients. They have completely different needs than my son. You cannot fit the 18-year old and the geriatric patient into the same patient and have it be responsive to each.

ED HOWARD, J.D.: Steve?

STEVE LIEBERMAN: Joann, your work in dealing with people at end of life and issues like that clearly the question of how Medicare deals with complex social needs that are outside of an acute care benefit package is – or any healthcare system – is an important social issue.

The problem, I think, becomes one from the question of matching the social need and social value with the question of the cost and particularly the question of when you are dealing with a federal benefit package, it is written as an entitlement package and how one then separates out the – at the margin, people who would not otherwise get the care versus people who are now getting care that is informal care, which is now monetizing versus other forms of expansion of benefits, which

may be a social good but it makes the problem of cost, I think, harder. And so I think your question in a broader sense illustrates the challenges that Cathy and Karen have been trying to take on, which is where you draw the lines.

In some sense, I think Gail it would be fair to say that your and my observations, to some extent, are applauding the comprehensiveness of the effort but denote that there is a problem with line drawing and there are some really significant questions that have not been addressed. I think this is a classic case and I do not know what the judgment is but it is clearly a policy judgment of where we may have the better be the enemy of the good.

ED HOWARD, J.D.: Yes, go ahead Karen.

KAREN DAVIS: I know we have got a lot of question so I will not take much time but I think the one thing we all agree on here is we want a patient responsive patient-centered system. So a little bit the question is whether people are better off taking their bundle of money and trying to find it on their own or whether the Medicare program really needs to try to be a leading innovator on delivery system reform and developing different models of care for the work, Joann, that you have done on the different stages.

Certainly, I think this whole concept of a patient-centered medical home is an important beginning and obviously

Medicare is in the throes of designing a demonstration of that given the legislation that Congress enacted in December of 2006.

But I think we will have to evolve that concept to have a somewhat different model for patients at the end of life, patients with complex conditions but not at the end of life and those, as you say, who are the relatively healthy, whether it is near elderly or those newly eligible for the current Medicare program and then to link that with payment reform.

So there is the incentive to make prudent use of resources but have bundled payment with greater flexible for trading off the kinds of services that are used to reach that, to allocate those funds.

ED HOWARD, J.D.: If I can ask at the forbearance of the folks at the microphones, I wanted to pick up a couple of questions that were actually referred to indirectly by what Joann was talking about, you made the observation that the Medicare program seemed better suited to the near elderly than to the elderly.

And a couple of the questions come from the viewpoint of worrying about the impact of the proposal to allow a buy-in to Medicare on the fiscal soundness of Medicare, on the pool of risk for Medicare, and how the financing mechanism for that

particular part of the plan might work and I wonder if anybody would like to respond to that. Cathy?

CATHY SCHOEN: I will try to do it in a short way. I think Gail, you pointed out in the article, we did not do a lot of modernizing of Medicare and there were a few things. One, Health Affairs has a word limit but I think we are absolutely talking about a modernized Medicare, a different way of paying and one of the issues even with a buy-in was buying in not to the type of benefit structure that currently exists where when you buy the basic Medicare now, you need to buy two other supplements.

You would never have that, you do not have that in the group. So it was both trying to set up a more comprehensive benefit package – by comprehensive meaning all the pieces work together and that buy-in was set. The estimates were an actuarial fair premium. So it would not be, as Cybele said, it is not buying in to the trust fund per say. It is buying in at a premium level. So it does not add to. It is not a new entitlement.

So that is the way the vision was but I think if you read more broadly some of what we put out in a recent report called “Bending the Curve,” that is available on our website, trying to think of not just what the benefit package looks like

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but the way providers are being paid for benefits, as Karen mentioned, a medical home.

Medicare is talking about paying differently. Medicare was the innovator in bundling payments for hospitals with DRGs. There is a potential of moving away in an incremental way with offering new ways of paying so that you can get more comprehensive geriatric care or chronic care where physicians can be working with nurses.

We see some of that innovation happening both in the private sector but also internationally. As other countries who are also searching for a way of pulling the system back together and having it be more coordinated. We need that innovation in Medicare. W

e need it in the private sector and something like a connector that allows the two to play off each other, offers the possibility for stimulating more creative and constructive directions in the future so that the vision was not just coverage based on the all but it was coverage plus a broader set of system reforms because I think we absolutely have to do it.

I just want to say one thing about the Lewin estimates too because Lewin, if you look at the estimates, the coverage alone that was in the proposal in Health Affairs was not fully

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funded and they absolutely in out-years if we do not do something to slow the growth, the federal cost accelerates.

So we have done some offsets for that initial financing but I think coverage without the supplemental system approaches, we will find ourselves how do we maintain the premium? How do we maintain the subsidies? So there is that interactive out-year where the coverage proposal not coupled with payment reform would be expensive over time.

ED HOWARD, J.D.: Karen do you want to add to that and then Cybele?

KAREN DAVIS: Yes. Just since our Lewin colleagues, as far as I know, are not here to defend themselves, I might also address this fact that the Medicare Extra benefit package has a premium about 30-percent below what employers are paying, kind of shocked me the first time I saw it and we probed quite a bit on that but when you think about it a little bit, Medicare's administrative costs are two percent.

For employers, it is 15 to 20-percent. Actually if you are talking about the small, individual or small business market, you may be 30 to 50-percent overhead on top of that. So you are trading those administrative costs for Medicare.

Then there is the fact that Medicare pays hospitals about 15-percent less than commercial payers. It pays physicians about 20-percent less than commercial payers.

So if you have got savings of 15-percent or so on administrative costs and you have got savings at 15 to 20-percent on provider payment, the fact that you wind up with a 30-percent savings on premiums is really not as surprising once you parse it out.

So I will leave it to Lewin to defend their estimates and certainly, one will see at some point in time if this ever moves forward, what a CBO price is for that but those are some of the elements that go into those kinds of differentials.

ED HOWARD, J.D.: Yes? Go ahead Cybele.

CYBELE BJORKLUND: I would just make the same case there. I mean one of the reasons when Chairman Stark and Chairman Rangel and others who have been at this for a long time keep returning to variations on the theme around Medicare is just that in terms of the ability on the efficiency side.

But I wanted to actually just to reiterate that for us too, although I focused on sort of Medicare as a vehicle given the topic, when we look at reform, it really is a three-legged stool – cost, coverage, and quality and it goes back to Gail's point too that as goes Medicare, so goes the rest of the system and vice versa.

You cannot tease out a lot of the cost issues we are having in Medicare from what is happening elsewhere. So that is very much on our frame of mind as well and I think when you

look at Medicare, the other thing both for as it exists today and as a model for the future, there is a huge continuum between completely a la carte fee-for-service payments and giving private insurers a capitated amount saying go do whatever you want.

There is a lot that needs to be done and people have tried through the years. We had provisions in our Champ Act last year on this too, to get at bundling and feedback to providers and other kinds of things, medical home, to more fully integrate and coordinate care for beneficiaries who are in a fee-for-service program whether Medicare or somewhere else, that are a much more modern way of looking at than the a la carte but still do not necessarily offload with the attendant issues that we have got in the Medicare Advantage program.

ED HOWARD, J.D.: Good. Gail?

GAIL WILENSKY: Quick comment. The first is I would be willing to wager at least a good dinner at the restaurant of your choice that the CBO estimate looks nothing like the Lewin estimate. Let me just give you a couple of observations as to why I think there are some areas that just do not seem to make intuitive sense.

It is true that you are going to allow the Medicare pricing and that – that is lower but, of course, as we know

from Medicare Part B, having pricing is not the same as slowing down expenditures. Part B has been managing its 10 or 12-percent growth even though Medicare controls the prices. So it just is a clear reminder how what we fight most in this country is the volume in mix of services and we sometimes get too hung up on the prices.

The second is you will recall that there seems to be unanimous agreement that Medicare has absolutely starved the administrative structure and if you want anything like this, you are going to have to pony up a lot more money. So for God's sake, stop holding up Medicare as the model of administrative efficiency. It is as low as it has been.

One, because the Medicare spending part, the high denominator has grown so rapidly and two, because it is frigging starved by the administration and the Congress and that is why the amount is so small. So at least on the same panel, do not say that we need to be serious about how we are going to support the agency and, at the same time, exalt what we see now for its low program. We need to at least get through one session without having that contradiction.

ED HOWARD, J.D.: Quick word.

FEMALE SPEAKER: Can I just say just quickly, my boss has always put his money where his mouth is and he has repeatedly gone to approps [misspelled?] even under hostile

administrations to ask for more money for the agency for just that reason.

My point is only, it is actually less than two percent in admin. You could triple the resources and still be far more efficient than any of the private sector admin costs. So we are absolutely in favor and I love the idea of a mandatory draw but there are probably other committees that do not.

ED HOWARD, J.D.: The two people left at microphones have been very patient. Let me start with the gentleman at the far microphone.

WALTON DUMITZ: I have perhaps two questions and then a general comment.

ED HOWARD, J.D.: I will bet you have a name.

WALTON DUMITZ: My name is Walton Dumitz [misspelled?] and I am from the American Enterprise Institute and I am all for covering the uninsured. I think that that is great but I have a problem with the National Building Blocks approach. I do not know if I have a problem with it yet. So my question for Cathy is under the National Building Blocks approach, would you allow private insurers to compete in the national individual insurance market?

CATHY SCHOEN: Yes. Yes. External to the connector and internal to the connector, private insurance would still exist. So it could be offering either through the purchasing pool –

WALTON DUMITZ: Right. Would you open up and sort of stop restricting it at state lines? That is my question.

CATHY SCHOEN: We did not change anything about the state jurisdictions other than saying the connector is only going to operate in a region where the insurance market rules for everyone say it is not risk-related to health status so that there is an adjusted community rate. So for a state or region to do that, so it would be like a Massachusetts has those kinds of insurance rules and they have insurance companies competing with each other.

WALTON DUMITZ: Right. So if you let the government sort of provide insurance to a national pool where you distribute risks over the entire nation, to the individual insurance, which is something that to my understanding, private insurance would like to do but is not allowed to, then you have them coming into a market place that they do not currently exist in and competing on a level that you do not allow private actors to compete and so my question is, is that legal and/or ethical to do?

CATHY SCHOEN: I will try to understand the question but if the rules are the same inside and outside the connector and I think if you imagine what this does in a Netherlands for example. They have competing private plans working under a national framework. The plans operate in an Amsterdam as well

as other parts in the country, some are nationwide, but you actually by changing some of the rules and having everyone in, you probably lower the underwriting costs and some of the overhead costs in the small group and in the individual market by pooling those markets.

You are not really doing anything to undermine carriers. They could be offering, across multiple state lines, or through a national – either way as they do now. Their markets are very concentrated. All the big plans we see are operating in multiple states. So they are both operating in the state markets and in a national market. This does not really change anything about that.

WALTON DUMITZ: Okay. As long as they can compete in the same markets, it is fine. My next is a general comment and it seems to me and I do not have a PhD in economics but if you are going to increase demand by covering more people and you are going to decrease payment to people who provide the supply, you are going to eventually run into supply problems, maybe not tomorrow, maybe not next year, maybe not in the next ten years but at some point, you run into supply problems – not enough physicians.

ED HOWARD, J.D.: Would one of our PhD economists like to respond to that?

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GAIL WILENSKY: Yes. It really depends on whether or not you view this as a public utility model where everybody who is in it at a point in time is enfranchised in or recognized that in a world in which you may have individuals who are providing less than appropriate care or poor quality care that there are some individuals in some markets that are going to be pushed either to relocate, to do things that they are not doing now, that they do not prefer to do but that we should not look at this in a static world.

People ask a lot of times whether or not we have a shortage of physicians and the answer is it depends on how they practice. If they practice like they are practicing now, we will have shortages in a number of areas. If they adopt very different practice styles and look more like the Mayo Clinics, Intermountain Healthcare, Lahey Clinics, it is not clear to me that we have shortages in those areas.

What we need to understand, if we aggressively actually try to put the information out so there is much better information about what provides medical value and reward the clinicians in institutions who provide good quality care, are responsive to their patients, have good patient satisfaction, there is more than enough money in the system to take care of that.

It is some of the other institutions or individuals who might find a lot of downward pressure if we have a much more responsive system but I would not worry. When we get the kind of estimates of how much aggressively we do in this country compared to what other people do, there is a lot of potential for learning how to treat smarter, and learning how to spend smarter and not worrying about shortages unless we somehow feel we have to enfranchise everybody who is out there who is not responsive to the new pressures.

ED HOWARD, J.D.: Steve?

STEVE LIEBERMAN: I agree with what Gail said. I just want to add the slightly different perspective but I think it is entirely consistent, which is the work of Jack Wenberg [misspelled?], Elliot Fisher, and so on and in their seminal article in the Annals of Internal Medicine about four or five years ago, one of the most important findings they had was more care is not better care and there is some suggestion that more care may actually be worst.

So that I think clearly, the question of how one deals with the redistribution and the winners and losers in disruption of moving to less intense use of care is, I think, going to be an extraordinarily messy and politically fraught set of changes but as a theoretical issue, clearly if we knew how to move to efficient levels of care and to avoid supply

sensitive services to adopt their framework, their estimates that they have done that suggested that would lower Medicare spending by about 30-percent.

Now the question of how you move those is an entirely different question but I think, from an abstracting, to me the really important point is because of the way the current system works, we clearly have incentives for people to provide care in ways that are not patient-centric, that are not best for the patients and that allows the potential if we can figure out how to organize and harness that.

I think that is a lot of the work that trying to build a high performing health system that group is focused on and there are other efforts obviously but I think that becomes a real mediating factor before you get to the almost Malthusian kind of implication of your question.

ED HOWARD, J.D.: Congressman Price?

REP. TOM PRICE (R-GA.): Very briefly, more care is not necessarily better care but no care is no care and the sense that there may be a challenge to the supply of providers out there at some distant date is just is not the case.

The challenge is today. Twenty-five percent of the practicing physicians out there who see Medicare patients are limiting the number of Medicare patients that they see.

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If this is such a wonderful system, it is imperative that we ask the question why. Why are those folks not seeing new Medicare patients? Find the closest person that you know, parent, grandparent, aunt, uncle, spouse who has come of Medicare age in the past year and ask them – did you have any difficulty finding a new primary care physician for Medicare and the likelihood is that they did.

So we have a challenge to the supply right now, which makes it imperative that we look at the system and answer the questions why is it that providers are not universally participating in the program.

FEMALE SPEAKER: On the quick note on that is just that again, as goes Medicare, so goes the rest of the system. I have FEHBP Blue Cross. It is widely talked about as the gold standard and here in D.C., I do not have a pediatrician or an internist who takes it. I am self-paying to the tune of thousands of dollars out of NFSA on top of a $14,000 a year premium paid by the government and myself for primary care for a healthy family.

ED HOWARD, J.D.: Okay. Yes? Thank you. You have been very patient.

JONATHAN: Thank you. Jonathan [interposing] Institute for Alternative Futures. Across the Hill earlier this year at a hearing I heard the phrase hollow government syndrome applied

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to an agency that has had more mandates put on it without more capacity built into it and I have heard today from three of you on this panel that CMS may be, to some degree, at risk for this kind of hollow government syndrome.

I would like to ask how big is that risk in your view over the next few years.

ED HOWARD, J.D.: And with the qualifications with or without additional duties. Go ahead.

FEMALE SPEAKER: It is not a new issue. This is not a new challenger or issue for CMS and it happens for the reasons I suggested is that the administrative support is funded in isolation from running the program and competes against the rest of discretionary funding for the government. I think it has been a long-term problem and exists today and will exist unless there is a change in the funding mechanism.

STEVE LIEBERMAN: GAO, probably about eight or nine years ago put Medicare on the high-risk list for exactly that reason and I think at that time that was the 2000 report. The average tenure of an administrator, an acting administrator, was shockingly short counting the active administrators and I think the tenure has gotten no better in the last seven or eight years.

It is not just a resource problem, although clearly resources are a major issue and it is hard for an OMD budget

examiner to say that but clearly resources are a major issue and the lack of sufficient resources but it is also leadership. It is management.

I cannot begin to tell you how beleaguered people inside CMS feel. When they get it right, when they do exactly what Congress asks them to do, they get beaten upon. It is a very tough environment. I have worked in a lot of different places and CMS is a really hard environment. People get paid an awful lot more money to do other things in an awful lot nicer environment and until we deal with the policy and management challenges as well as the resource challenges, we really do have a dramatic risk and I will add one other thing.

My last job at OMB, I was the career assistant director and I was responsible for privatization among other things in the end of the first Bush administration. We had a doctrine of inherently governmental services. Among other things, contractors did not set policy.

Federal officials set policy. Because of the way CMS is hollowed out, it is my perception that an awful lot of policymaking gets done for a variety of reasons by contractors not by the institutional core.

So if you try to look at why did you do this in trying to simulate one of their complex payment systems, the answer oftentimes is it is in assess code that was written by a

contractor and we do not know. I do not mean to embarrass CMS here. This is not, in any way, suggesting that there is something wrong with them. It is a statement of fact of what I think is a hollowing out of government that has occurred over the last 15 years.

ED HOWARD, J.D.: I saw Stu Detterman [misspelled?] of the Commonwealth Fund, late of CMS, nodding in approval there. We have time for just one more question. Then I am going to draw from cards and I would ask you as we finish up here to pull out those blue evaluation forms and fill them out for us.

This question is addressed nominally to, oh I am sorry, go ahead. Stu.

STU DETTERMAN: I was not going to say anything but I was not nodding. I was shaking my head the other way.

ED HOWARD, J.D.: I see.

STU DETTERMAN: Actually, it is my perception that most of the decisions at CMS are made by the political appointees and they are implemented pretty much by the career people with help from contractors in terms of some of the parameters but I think they are pretty – my perception was they were pretty carefully thought out last I looked.

There is obviously some conflict occasionally between the political appointees and the career people at CMS and that is going to happen.

ED HOWARD, J.D.: Okay. You certainly had the right of personal privilege as they say. This question is nominally addressed to Congressman Price and we will give him first crack at it but I think it raises a point that everybody on the panel has at least touched on and I would welcome other responses.

The question asks Congressman Price how your patient-centered approach controls cost increases and I would ask more generally we have heard from many of you about how important and even overriding the cost question is and in lieu of all of the things that you dismiss as not working, what is it that you propose to try to make this system a more efficient cost effective way of doing business. We will start with Congressman Price.

REP. TOM PRICE (R-GA.): Thanks Ed. Let me thank you all again for allowing me to participate on this and I just want to toss my remarks in favor of the folks at CMS and the job that they are doing. I would not have that job for anything. I do not envy the work that they are doing. Can you imagine having your boss change every four to eight years without your control at all and you have got no control over that. I would not have it for anything.

How do you control costs? Well you have got to answer the question,– what drives costs? What is driving costs in healthcare in order to figure out how you are going to try to

control costs and what drives costs in healthcare, our healthcare system, is no different than that which drives the costs in any other business or endeavor and primarily, it is taxation, litigation, and regulation.

So if you control the issues of taxation, litigation, and regulation and litigation not just in a liability system for medical liability but in the ability of physicians to police their own ranks. Right now they are unable to do so, I would suggest, because of liability issues. So taxation, litigation, regulation adds remarkable amounts to the cost of healthcare.

The second question that one has to answer in terms of costs is what should healthcare cost in our nation? I do not know what that number ought to be but I know how you get to that number in a free society and it is allowing free individuals to determine how much they wish to spend on healthcare.

That is the way that you get to the right answer. Is it 16-percent of GDP? I do not know. Is it 20-percent? I do not know. Is it 12-percent? I do not know but I do know how you get to the answer to that question and it is not, the answer to the question is not one that ought to be determined by individuals in the surrounding environs, the answer to that question is to

allow patients to determine how much they wish to spend on healthcare.

ED HOWARD, J.D.: Others? Cybele and Karen.

CYBELE BJORKLUND: Well I think again, our concern is in terms of the individual empowerment around cost. I think a lot of where you are going to try to influence cost once you have better data is around clinicians and helping clinicians be better clinicians as they take care of the patients relieving them of some of the business obligations and allowing them to do what they were trained to do. Most of them did not go to business school. They went to medical school but there is still so much uncertainty around what works and what does not work.

Patients are bad consumers, partly they do not have good information but you are in a vulnerable state and there is a mismatch of the information that you have and I think people are fooling themselves if they think that putting patients on the hook for this is going to materially change.

It may force people to forego care that they need and they present sicker and actually increase total spending but basically, we believe that although information is a good thing, it is never going to be like buying a car and I do not care what car Gail buys. That is her business but I do actually care what she buys in terms of insurance because in the market we have today, if there is a massive opting to high deductible

plans, the rest of us who do not want to opt there have our choices affected by other people's choices.

So it is a very dynamic and different market from a traditional market. I think we have to be very aware of that looking forward when you look at the incentives.

KAREN DAVIS: Well I think there is no silver bullet that solves the cost problem but I think there are a number of very real options for slowing the rate of growth in healthcare outlays and if we do a number of things that make sense and we start soon, they will have a major cumulative effect.

Just to give some examples, the churning of insurance coverage – people enrolling, disenrolling, re-enrolling creates costs. We need greater standardization. We funded a study to look at administrative costs and one of the greatest costs of physicians' time are formularies.

So the patient gets a prescription, goes to the pharmacy – it is not covered by that plan. So they have got to call the doc, change the prescription. So the physician does not know what is going to be accepted at the time that they write it.

I think we have seen some of the CBO analysis of that but in the "Bending the Curve," we designed it with real teeth and that came from having an assessment on insurance companies to go to state governments to really help small physician

practices and safety net providers that are not going to be adopting IT any time soon.

Without that kind of support on comparative effectiveness, it is linked, again in the Lewin estimates, to real teeth that cost sharing - that you pay the difference if you want something that is no more effective but costs more, whether it is a drug, device, or procedure, you pay the difference.

So I think those are things that we can do but, in my own view, the fundamental secret to dealing with healthcare costs is delivery system reform and that means valuing primary care.

When I look at the difference between the U.S. and other countries, the real difference is the differential between primary care and specialty care. I think for Medicare, we need to think about new provider types going beyond just physicians and hospitals to really having primary care group practices, multispecialty group practices, hospital systems that have their own physicians, integrated delivery systems, and we need new bundled payment mechanisms that are attractive to those kinds of organizations to take accountability both for care and health outcomes but also the prudent use of resources.

So I think, in my own view that is the key to the future. The Commonwealth Fund is working on two reports, one

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that we anticipate releasing in July on options for reorganizing the healthcare delivery system and one that Cathy is hard at work on that she is looking at me for the date that I am going to promise it but early next year on a path to high performance, which is a combination of all of these strategies that it takes us to really get to where we ought to expect and ought to demand that we go as a country. Thank you.

FEMALE SPEAKER: I like – it is an area where actually there is large areas of overlap in terms of not only spending more in terms of knowing the value of what is being provided and constructing reimbursement systems so that you reward those areas that have high value and you let people buy up for those areas where they are low value.

I think it is an area where we could combine what is physicians' interests traditionally in terms of liability reform and begin to provide protection for physicians who have a standard set of patient safety measures, and follow clinical guidelines developed by their colleges that they be not subject to punitive damages unless there is clear evidence of criminal negligence, that this would take away one of the drivers that frustrates many physicians and not only are they not incented to do what counts and to do it well and be responsive to their patients but they put themselves at some legal liability.

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If there is a bad outcome and they do not have that kind of protection, it seems to me a very clear way to marry the interest and evidence-based medicine that has created interest on both the right and the left with providing something that has been a thorn in the side of clinicians and to recognize that this is going to be an [inaudible] of process over time.

It is discouraging but not surprising in any way that CBO has taken the position that health IT per say, is not going to save money but particularly in terms of comparative clinical effectiveness, may allow the mechanism you need in order to implement that.

I do think that we can use payment strategies to help fund the adoption of IT for groups that are not likely to have access to capital like small groups of physicians particularly rural physicians or small rural hospitals perhaps and just remember that we have enormous numbers of freestanding cardiac and orthopedic hospitals and imaging centers, a clear reflection of a misalignment in payment and if we begin to use some of that same kind of strategy of changing what we are paying for.

We can help provide the money that would be needed to reconfigure the delivery system. We know it works. We just do not like what we have done thus far.

ED HOWARD, J.D.: Very good. Anybody else? Okay. Well this has been a session of which I have learned a great deal, I want you to know and I want to thank the Commonwealth Fund for its support and co-sponsorship of this program as well as its contribution to the panel.

Take a special word for the Fund and the Alliance staff who worked on this. It was, as you see, a multifaceted discussion and it was multifaceted in the ways in which it came together and thank you for your hard work.

I want to just commend all of the panelists and I particularly want to say a kind word about Congressman Price in absentia. He had another meeting he had to go to. He sort of walked into the lion's den of the economists and came out largely unscathed I would say and that is very, very brave.

And I want to commend him for it but all of the panelists have been extremely useful and extremely eloquent in their explanation of some of the problems and some of the suggestions for dealing with those problems and I ask you to join me in thanking them for allowing us to sit in on this discussion [applause].

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