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Medicare 101
Alliance for Health Reform and The Kaiser Family Foundation
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ED HOWARD, J.D.: I am very pleased to welcome you to this program on the basics of Medicare, Medicare 101, a primer on Medicare. Call it what you will. You get the idea. On behalf of Senator Rockefeller and Senator Collins, our board of directors, welcome to this briefing. Thank you for coming.

You know I suspect, we were talking, there are a lot of people in the audience who probably should be on the dais here, so you don't have to listen to this part, and the only thing I think you should be doing in this briefing is to make sure that when one of us makes a mistake, you can correct it.

But for those of you who really do need a 101 briefing, Medicare is the largest single federal health program. It covers 45 million people at a cost that is going to approach half a trillion dollars in 2009. And along with social security, it is the most popular federal program, even though its coverage is a lot less generous than the policies most of us in the working world have through our employers.

And even though the trust fund is approaching a zero balance for hospitals in just a few years, I particularly hold it dear to my heart since both my wife and I are now eligible for Medicare and it has made life a lot easier in finding a primary care physician who is consistent with our view of the way the insurance system ought to work.

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Our partner and cosponsor in this briefing, The Kaiser Family Foundation, has been doing work on Medicare for years and the highest quality of work. Diane Rowland, who you will hear from in just a moment, is the executive vice president of The Foundation and one of the country's leading health policy experts.

We want to welcome not only those of you here in the room in Washington but also specifically the congressional staff listening and watching a live webcast of this briefing on kaisernetwork.org in the state and congressional district offices around the country. I want to thank you for tuning in. Even in the long ago days when I was on the hill working in a congressional office, Medicare generated an enormous amount of mail and case work for our district offices and I think you will find the discussion today really useful to get better informed about Medicare.

As far as the congressional staff here in D.C. are concerned, you may not know all of the details of Medicare but you probably do know that unless congress acts by the end of the year, Medicare payments to physicians are scheduled to decline by more than 20-percent which may prompt a few physicians to communicate with their members of congress at about that time.

So at this point, let me call on Diane Rowland of The Foundation for observations she can make at this point.

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DIANE ROWLAND, Sc.D.: Well thank you Ed and thank you all for being here for our basics of Medicare briefing. I think you will find that the information will help you to at least understand the ABC's and D's of the Medicare program and I know that it will be an issue that all of you working on the hill and those working on issues for the aged and disabled will encounter over the coming year because Medicare as Ed said is front and center in the way in which we provide health care services and coverage to the elderly and people with severe disabilities.

In terms of the congressional action, it is also a program that in the house at least spans two committees of jurisdiction, being in the ways and means committee for Parts A and B as you'll learn, and in energy and commerce around Part B, so it is an interesting program from the issue of politics of congressional jurisdiction in the house.

In the senate, it is under the jurisdiction of the finance committee. So, that looking at the program, looking at how it is part of the entitlement debate, looking at how is going to fit in to health reform and how its sustained for the future as a program itself is the point of setting the framework today by helping you to understand some of the key issues on the beneficiaries that it covers.

On the elements of the program's design, on the payment issues, which as Ed mentioned you will hear about it from the

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doctors but also from the health plans known as Medicare Advantage Plans. And on the financing issues, so without further ado, I will turn it back to Ed so we can get started on our trip through the ABC's and D's of Medicare. Thanks.

ED HOWARD, J.D.: Terrific, thank you Diane. A lot of good information in your packets that I want to commend to you including speaker biographical information to supplement the inadequate introductions they will get from me. You will also find Power Point presentations in those materials.

Those watching the webcast can find these same materials at the Alliance website at allhealth.org, all one word, and you will be able to see a transcript of today's briefing in a few days, a webcast archived will be on the Kaisernetwork.org website either tomorrow or the next day. You have green question cards in your packets.

I would appreciate it at the appropriate time to fill out a question on the card, hold it up and someone will bring it forward. There are also a couple of microphones that you can use to ask your question vocally and if you are watching on the web, you can email us a question that we will make sure gets answered at that point.

Now let's get to the program. We really have a terrific group of folks as resource people today. They are going to give brief presentations and we will have a lot of time for your questions which we hope will be numerous and fact

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based. We are not planning to argue out the future of Medicare today. We want to get everybody in the room up to speed so that they can have the conversation about the future of Medicare later on.

So, we are going to start off with Juliette Cubanski, who is principal policy analyst for The Kaiser Family Foundation. She is an expert on Medicare financing issues and on the Part D drug benefit. She holds a doctorate in health policy from Harvard. Her task today is to give us a broad overview of this important program and it is great to have you Juliette for the purpose of setting the stage for today's discussion.

JULIETTE CUBANSKI, Ph.D.: Thank you Ed. Thank you Diane. I am Juliette Cubanski, a policy analyst for The Kaiser Family Foundation and as Ed said, my role here today is to give you some essential facts about Medicare, who the program serves, what benefits are covered, and the current picture of Medicare spending and financing.

Medicare was established in 1965 as a social insurance program for people aged 65 and older and was expanded in 1972 to cover younger people with permanent disabilities. Today, Medicare covers 45 million people, 38 million 65 and older, and 7 million with disabilities. Medicare covers people without regard to their income or medical history and provides the same benefits to everyone entitled to coverage. This is an

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important feature of Medicare that distinguishes it from Medicaid and private health insurance coverage.

Since 1965, Medicare has provided access to services critical to the health of elderly and people with disabilities including hospital and physician visits. The program was updated in 2006 to include a prescription drug benefit delivered through private plans, providing the drug benefit through private plans was a significant change in the delivery system for Medicare and private plans have been playing an increasingly larger role in the delivery of Medicare benefits as I will discuss in a moment.

Medicare covers a population with diverse needs and circumstances and one which on the whole tends to be sicker and have greater health needs than others. Over one third have three or more chronic conditions and 29-percent have a cognitive or mental impairment. The oldest old, those aged 85 and older, are about 12-percent of all Medicare beneficiaries but as the U.S. population ages, the represent a growing share of people on Medicare.

Many beneficiaries live on modest incomes, primarily derived from social security, with almost half having annual income less than 200-percent of poverty which was just over $20,000 for a single person in 2008. And a small share of beneficiaries live not in their homes or other community settings, but in long term care facilities where they use

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services at a higher rate than other people on Medicare, reflecting their more fragile health status.

For the majority of beneficiaries, Medicare benefits are provided on a fee for service basis, referred to nowadays as original Medicare. Benefits for hospital and physician services are divided into two parts, Part A and Part B. Part A is the hospital insurance program, which helps pay for hospital visits and skilled nursing facility stays, post-acute care, and hospice care. Medicare charges a deductible before it begins paying for hospital stays, an amount just over $1,000 in 2009 and also charges for each day of an extended stay in a hospital or skilled nursing facility. Typically people gain entitlement to Part A after paying payroll taxes for at least ten years.

Part B is a supplementary medical insurance program which helps pay for outpatient hospital services, physician visits, lab work, and preventive screenings. Most beneficiaries enrolled in Part B are required to pay a monthly premium which was over $96 in 2009 but this premium is income related, meaning that people with higher incomes pay higher monthly Part B premiums. Part B services are also subject to a deductible and most Part B services are also subject to coinsurance of 20-percent. Enrollment in Part B is voluntary but most people who are entitled to Part A also enroll in Part B.

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Part C and Part D which I will talk about next are different from original fee for service Medicare because they involve delivery of Medicare benefits through private plans. Part C, now known as Medicare Advantage, offers an alternative to fee for service coverage of Medicare benefits where beneficiaries can enroll in a private plan, such as the health maintenance organization or preferred provider organization or a private fee for service plan.

These plans contract with Medicare and receive payments from the government to provide enrollees with all Medicare covered benefits and often extra benefits that Medicare does not cover, such as vision and dental services. Now, according to the Medicare advisory commission, Medicare pays more for people enrolled in Medicare Advantage Plans, 14-percent more on average in 2009, than it would pay for these same individuals if they were covered under original Medicare.

Tom will be talking to you shortly about the details of this payment system but the point I want to make here is that these payments have encouraged large scale expansion of Medicare Advantage Plan availability in recent years, which helps to explain the dramatic growth in Medicare Advantage enrollment since 2005.

And it is also worth noting that the Medicare Advantage Payment System is likely to get a fair amount of attention in the weeks and months to come, since it is targeted in President

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Obama's budget as a source of revenues to help pay for health reform.

So, as of February 2009, just almost 11 million beneficiaries, which is nearly a quarter of all Medicare beneficiaries, are enrolled in Medicare Advantage Plans. These enrollees pay the monthly Part B premium, typically they also pay a premium to enroll in the Medicare Advantage Plan, which usually but not always includes coverage of the Part D drug benefit.

Part D is a voluntary outpatient prescription drug benefit delivered also through private plans, either stand alone prescription drug plans which supplement original Medicare or Medicare Advantage Drug Plans. The Part D benefit was established by the Medicare Modernization Act of 2003 and was launched in 2006.

Prior to that point, Medicare beneficiaries did not have access to drug coverage subsidized by Medicare. Part D represented a large expansion of the role of private plans in Medicare and in each year since 2006 beneficiaries in each state have had access to dozens of Part D plans. Plans are acquired to provide a standard benefit with a deductible coinsurance for prescriptions, a gap in coverage, and catastrophic drug coverage.

The gap in coverage, commonly known as the donut hole, is where beneficiaries must pay 100-percent of the cost of

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their drugs until their spending reaching the catastrophic level. Plans are allowed to vary the design of the benefit and in fact most plans offer something other than the standard design, but most plans do have a coverage gap.

Beneficiaries with modest income and assets are eligible for additional assistance with their Part D premiums and cost sharing and more than nine million people are receiving these extra subsidies, although there are also another 2.6 million estimated to be eligible but not receiving the extra help.

In total now, 90-percent of beneficiaries have some form of drug coverage including nearly 27 million people with Part D drug coverage. The latest estimates indicate that 4.5 million people or nearly 10-percent of Medicare beneficiaries, lack any source of drug coverage in 2009.

So, providing all these benefits does not come cheap and Medicare benefit payments are estimated to total $477 billion in 2009. Presently, Part A benefits in particular hospital services comprise the largest share of Medicare benefit payments followed by payments to Medicare Advantage plans for Part A and B benefits, and then payments to physicians and other suppliers.

Spending on the Part D drug benefit accounts for 11-percent of benefit payment in 2009 and the congressional budget

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office projects that in the coming years prescription drugs will grow to 16-percent of Medicare benefit payments.

The different parts of Medicare are funded in different ways. Part A is funded primarily through payroll taxes. These revenues from which the Part A trust fund will derive 85-percent of its revenue in 2009 are dedicated tax on earnings paid by employers and employees. Part B and Part D are financed primarily through a combination of general revenues and premiums paid by beneficiaries. Part D is also partly financed with payments from states.

Funding for Part C, the Medicare Advantage Program, is not shown here because funding is not provided separately for Medicare Advantage Plans. I should note that this point in time snapshot of revenues does not convey Medicare's long term financing challenges which I know Marilyn will discuss in more detail.

But, according to the Medicare actuaries, spending on Part A benefits is expected to exceed the revenues coming in, in 2010, so next year Medicare will need to rely on revenues that have been built up in the Part A trust fund over the years in order to fully pay for Part A benefits and the actuaries have also projected that these reserve funds will be fully depleted in 2019, meaning there will be insufficient funds to pay for all benefits that year, so future financing issues are a likely focus of lawmakers' attention in coming years.

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And despite the important benefits that Medicare covers and the large sum required to pay for them, there are gaps in the Medicare benefit package. Medicare does not cover vision or dental services, nor does it pay for most long term care services for those beneficiaries with extended care needs in a nursing home.

Medicare also has premiums and cost sharing requirements that could prove burdensome for beneficiaries with fixed incomes and significant medical care needs and has deductibles for Part A, Part B and Part C that are indexed to increase each year and make Medicare look more and more like a high deductible plan.

And then, like typical large employer plans or feed, Medicare does not have a stop loss benefit that limits how much beneficiaries have to spend out of pocket in any one year on the benefits they receive. And in fact, Medicare pays less than half of beneficiaries total health and long term care spending and is less generous compared to typical large employer plans or feed, so to help with these expenses and provide coverage for benefits that Medicare does not cover, many beneficiaries have some form of additional insurance coverage.

The primary source of supplemental coverage for one in three beneficiaries comes from employer sponsored retiree health benefits. Medicare Advantage is another source of

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coverage for a growing share of beneficiaries, supplemental in the sense that these plans often provide coverage for benefits Medicare does not cover.

Private insurance policies known as Medigap which cover approximately 18-percent of beneficiaries, primarily help cover beneficiaries cost sharing for medicare benefits but these policies are often quite expensive and may be growing less attractive to beneficiaries as Medicare Advantage has expanded in recent years.

Last but by no means least; state based Medicaid programs provide a vital source of support and benefits for more than eight million Medicare beneficiaries with low incomes. People on Medicare who qualify for Medicaid coverage are referred to as duel eligibles and most receive full coverage of Medicaid benefits that Medicare does not cover which notably includes long term care.

In addition, Medicaid pays Medicare's premiums and cost sharing requirements for the dually eligible population through the Medicare Savings Program. So, this leaves roughly one in ten beneficiaries with original Medicare and no other source of supplemental insurance.

An area of great concern is that employer sponsored coverage for retirees has been eroding in recent years as the cost of offering this coverage has risen and this could focus attention in the coming years on the adequacy of Medicare

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coverage and on ways to bolster and improve the Medicare program so that those without supplemental coverage, as well as all others on Medicare, are less vulnerable to rising health care costs for the important benefits and services that Medicare provides to a growing share of the U.S. population. And with that, I will turn it back to Ed.

ED HOWARD, J.D.: Thank you very much Juliette, an excellent beginning to this conversation. We are going to turn now to Tom Gustafson, who is a senior health policy advisor with Arnold and Porter, a major D.C. based law firm, many of you have heard of. Tom is an economist. His Ph.D. is from Yale.

And, he spent 30 years at the Department of Health and Human Services, most recently as the acting director of the Center for Medicare Management. Now, that center as you may know coordinates fee for service Medicare and sets major payment policies for the program. He led the development of the hospital outpatient payment program, deeply involved in some other payment reforms and he is here to tell us more about payment issues. Tom, thanks for being with us.

TOM GUSTAFSON, Ph.D.: Thanks very much, Ed. Talking about payment, we need to look at what we are paying for. This is a close cousin to the slide you saw a moment ago, although my year is a little bit different than the prior one and the numbers are broken up a little bit differently.

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That is not really very important. The key points I would like you to take away from this slide is that two-thirds of the spending is in fee for service, in the basic fee for service A and B benefits. Managed care represents about 20-percent of the spending as it represents about 20-percent of the case load and over time although the managed care portion of the Medicare case load is expected to expand, the total number of people involved in fee for service, enrolled in fee for service, is likely to stay roughly the same.

You have about give or take 35 million beneficiaries in that program so it is the dominant payment scheme. The large blocks of color you see here are where you are likely to be hearing, particularly those of you on Capital Hill, where you are likely to be hearing static over the course of the year on managed care, on physicians, perhaps on hospital inpatient, but there are a lot of different payment systems in Medicare.

The next slide, I am on slide three here for those of you on the web, shows just a capsule snapshot of the spending in different settings that Medicare is engaged in. The middle column shows the number of providers in each case, and an important point is that there are lots of them, particularly physicians. Every congressional office will probably be hearing from physicians over the course of the year and there are a lot of them in every district.

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There are also a lot of hospitals. The two different kinds of hospitals noted there are basically the big guys who are paid under the prospective payment system. That is what PPS means. And small rural hospitals, fewer than 25 beds, are called community access hospitals. They are paid on a cost basis. So, it is a little bit different.

The right column shows the eye-popping numbers associated with this. You have got $100 billion going out the door every year in payments to hospitals just for inpatient services. Payer shares here are not shown but are kind of interesting just to kind of help you navigate, somewhere in the neighborhood of 45-percent of the payments to hospitals are from Medicare, so no hospital in the country with few exceptions can do without Medicare business.

It is really important to them all. Physicians, the number is something between 25 and 30-percent, depending on how you count, and it varies a lot by specialty. Geriatricians as you might expect, it is very high, pediatricians very low, but in general something less than a third of the nation's physician bill is paid for by the Medicare program.

These different payment structures here are grouped in the two parts of the program on the fee for service side that Juliette just got done describing and I have put up here on the slide the major benefit elements that are in those two, there are lots of others, and just to help you think about it, when

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you are talking about Part A from a benefits side, think facilities, think brick and mortar, think you are paying money to hospitals and organizations that are like hospitals. On the Part B side, think ambulatory, think paying doctors for other services that are delivered to people in the ambulatory setting.

The fee for service payment, how do you set payments? How are people paid? It is very important to realize that we no longer pay on the basis of a provider's cost or on the basis of their charges. Over the last 25 years or so in a major intellectual achievement of this society, although one given very little respect recently, we have moved for paying under Medicare on the basis of prospective payments where the payment rates are set in advance. That means the hospital knows how much it is getting, if it has a case that comes in that needs to have the spleen removed, and Medicare knows how much it is paying for that service as well.

These payments are based on average resource consumption. It is an average across providers. And resource consumption means basically how much does it take to deliver the service? The important difference, the important concept to keep in mind there is this is not a value proposition. The payment systems are not set up to pay in some sense for how much a service is worth to society, to the individuals

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involved. It is based on average cost basically, average work, things of that sort.

In this context, individual providers can rise or fall. The Medicare program is concerned about access to beneficiaries, access of beneficiaries to services, not terribly concerned with the fate of individual providers, and that is something that sometimes comes as a disappointment to some providers who find themselves in a disadvantageous cost situation.

There are at least 12 different payment systems. One of the prior slides showed you a few of those but there are a bunch. One is for ambulances, for clinical lab services, for durable medical equipment, each one of these is separate, they are defined by their own trunk of statute and they are typically referred to as being siloed so it is very difficult to pay attention to how cost savings in one of these systems may affect spending or savings in another system.

Talk about how these payments are set, just to sort of play professor here for a little bit, I am going to take us back up to about 30,000 feet and imagine that you are in the business over at CMS of trying to figure this out. You have a large, large number of services that are delivered every day to people in health care settings, in a number of different diagnoses and conditions, much less screening and preventative services.

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Those services are classified by the Medicare program into buckets, different buckets for different payment systems. They are typically based to some extent on the resources used within that bucket, but also on the clinical characteristics of what is going on with that. Each one of those classes is in turn assigned what is called a relative value, so you will hear people talk about relative value units or how are the relatives set?

That sort of this is up, this is down. Come back to that in a moment with a more concrete example, and then in order to calculate a payment rate, you take that relative value, multiply it by $1 figure, usually $1 figure in each payment system, referred to as a conversion factor or a standardized amount, there may then be adjustors of various sorts, the most prominent one is geographic, so that in order to reflect the difference in wage levels for instance in different parts of the country, the payment rates will vary in different areas.

The first example here, I am going to run through two very quickly, inpatient hospital perspective payment system, sometimes referred to as the PPS, is just the granddaddy. It goes back 25 years now. The grouping, the classification system I spoke about a moment ago, are called diagnosis related groups or DRGs. When somebody comes in and needs services in a hospital, the hospital reports to the Medicare program what the

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diagnoses are attached to that case and they can be multiple diagnoses, 10, 12, 15 if need be, I suppose.

Speaking here incidentally about the payments that are made to the hospital, physician payments are separate and I will come back to that in a moment. Each one of these DRGs has been assigned a wait by the good people over at CMS, at the Centers for Medicare and Medicaid Services which runs this program.

The relative values go to the difficulty and the resources consumed in delivering that service and they can range anything from I imagine a fairly minor relative number for say setting a broken bone all the way up to a very, very high multiple for transplant. That is how that kind of works. They then get, that multiplication as I spoke of a moment ago, yields a fixed payment which is known in advance for that DRG and it is for an all inclusive bundle.

So everything that happens to that patient during that stay, lab tests, OR time, room and board fees, everything goes into the same thing and the hospital receives one payment at the end of the day.

In the physician area, it is a slightly different picture. This is where there are about 7,000 individual codes in this system so we are in the diagnosis reimbursement group system for IPPS, there are something in the neighborhood of 750 cells. Here you have like 7,000 cells, and it is a little bit

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like a Chinese menu, you can have one of these and one of those and two of those and an egg roll when you show up at a physician's office so they can be paid on the basis of the individual services rather than the large bucket of services for the entire time that they are there.

The payment amounts are calculated by adding together three different components which are shown here on the slide, physician work, the practice expenses which include stuff like both bandages and saline solution, things of that sort, that may be delivered, used in the course of the visit, as well as indirect charges like the time with the receptionist or the rent or the light bill, and then malpractice is a final element which is sometimes fairly controversial. Again, these payments are adjusted to reflect local differences.

You are definitely going to hear, those of you who are in any way associated with Capital Hill, are definitely going to hear about a physician payment over the course of this year. The reason is that the Medicare payment system has embodied within it something called the sustainable growth rate, or SGR, and that is if you will the source of the problem at the moment.

Basically what this says is that the updates that physicians will receive in the future are going to be adjusted, depending on whether their spending, total spending in the physician sector, is higher or lower than a particular target

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in the past. So, if the physicians are, if you will abstemious or if physician spending is below the target, then physician updates might be higher. If they are above the target, then physician updates are going to be lower.

The middle of the slide shows the factors that go into setting this. Inflation is one factor. The change in the number of beneficiaries, you kind of think you ought to pay attention to that if you are looking at aggregate spending in an area, you want to pick up those two features.

The third feature, projected growth in the real per capita gross domestic product, that is the kicker. The reason that is there is because congress wanted to constrain the overall spending on physicians to a rough proportion of the entire economy and in years when the gross domestic product was growing quite rapidly, that left lots of room for physician spending to grow.

Recently that has not been the case and that is why we are facing a 20-percent decrease in physician rates starting on January 1st unless congress acts in the meantime. So, buckle your seatbelts, there is probably going to be action this year.

The next, wrapping up here quite quickly I hope, just to note that is there a different way to go about setting payment rates? What I have just described is likely to seem highly complex to you and believe me it is what I have told you is only the most simple variant of it, people like me spend

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their careers worrying about this and start those careers with hair and you see what has happened to me in the meantime. [Laughter]

Competitive bidding is sometimes held up as a way that could be used in the Medicare program. There have been some fits and starts of using that. Most recent and most prominent and you will probably hear about this over the course of the year, those of you who are in congress, relates to competitive bidding for durable medical equipment. This was supposed to have started last year. There was a huge hue and cry about it and congress delayed it, but they did not extinguish it.

So, this project is on the books to come back to life again later this year and that is going to occasion some controversy because the folks who are subjected to it are not very happy about it all. This affects – you can see on the slide, I won’t go into it – nine cities to start. It is supposed to hit the largest cities and the most obvious targets of opportunity, the two items that are likely the most controversial here are oxygen and diabetic testing supplies and so there may be more discussion about that.

Medicare Advantage Plans are set by means of a complicated system starting from benchmarks which are established through bids coming in from individual plans and if the plan has a bid that is below the benchmark, then the government and the beneficiary basically get to split the

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savings, 25-percent of it comes back to the government, 75-percent goes out to the beneficiaries in terms of additional benefits, or reduced beneficiary cost sharing or premiums. This is fairly popular with beneficiaries.

If the plan bid exceeds the benchmark, then the beneficiary has to pay a higher premium to reflect that. The discussion you hear earlier, here is a slide that the Kaiser folks were kind enough to provide me, what this slide shows is the amount by which payments to the various forms of Medicare Advantage Plans and sure enough there are lots of different forms - I mean nothing can be simple in Medicare - exceed what would be paid to the same patients under fee for service medicare so this is the reason this is a target right at the moment, those numbers appear to many people to be large and as was previously described, President Obama has targeted them in his budget.

Last slide, I will just note that payments to Part D plans is kind of a similar business. There is a nationwide average bidding process, as you already heard Medicare picks up 75-percent of the tab on average, beneficiaries 25-percent that if the beneficiaries choose the low priced spread, they can be advantaged as a result of that, and there are subsidies from general revenues to those of low income.

In this area, one of the major issues you are likely to hear about goes under the words “non interference” which

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basically refers to the current provision which prevents the government from directly negotiating with drug manufacturers in order to get rebates. At present, the plan sponsors do that, can do that or are entitled to do that, and there are moves afoot to let the government into that game as well.

I will stop there. Thank you.

ED HOWARD, J.D.: Thank you Tom. Our final speaker is Marilyn Moon. She is the vice president and director of the health program at the American Institutes of Research. She has written the book on Medicare. I mean, literally written the book on Medicare. It is called Medicare: A Policy Primer in its latest iteration and I commend it to you. She has also been a public trustee of the program and we have asked her today to take a look at Medicare spending trends and projections. Marilyn, thanks for being with us.

MARILYN MOON, Ph.D.: Thank you. I think I am kind of the et cetera speaker here today and that is how I am going to take my task. I think Tom and Juliette both did a very good job of giving you a sense of the overview and I am particularly thankful to Tom for explaining the payment system. It is not one of the things I have spent my life doing and so I still have hair.

You all know that the projections for Medicare are expected to be such that there will be problems over time. Juliette told you a little bit about the exhaustion of the

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trust fund for Part A and the general revenues that go into Medicare grow actually even faster than the demands on Part A because they cover the parts of the program, B and D, that grow faster than Part A, and as a consequence there will be burdens that come from general revenues as well.

There was at one point a very poor measure of that as an indicator but suffice it to say if you look at Medicare as a share of GDP, it is of concern over time because it will gobble up more and more resources.

I am going to talk a little bit about how some of the magic bullets that people like to talk about are not necessarily the ones that are going to – could I have the little clicker – aren't going to be the ones that we want to think about necessarily and I am going to start with the first one which is an indication of just like health care for everybody else.

And in fact, if I took the Medicare population for people 65 to 69, you would see exactly the same kind of distribution and that is that there is a concentration of spending among a small number of beneficiaries. The top 5-percent of spenders among beneficiaries account for 43-percent of the costs.

Now you could say let's grab those people and change their spending habits. Part of the problem is there are all

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different sorts. In some cases, there are people with chronic conditions.

In some cases, there are people with very massive activity in one particular year that may be a one time only event such as heart bypass gone wrong with multiple hospitalizations and to some extent there are also people in the last year of life but don't believe the old saw that the last year of life is where you should concentrate all your efforts and you would be fine, because about 5-percent of beneficiaries die each year as well. And so if you say then is that that same 5-percent?

It absolutely is not and in fact the 5-percent who die each year count for about 28-percent of Medicare spending. They happen to be the sickest folks, that is why they die in many cases, and moreover that number has not changed very much, not leading us to believe we are piling more and more resources into the last year of life, for example. So, let's dispose of that old saw as an easy fix.

How about private sector good, public sector bad? That doesn't work so well either. These numbers come from the office of the actuary of national health statistics group there, and I have done some of these analyses myself over the years and while they are not perfect because they capture some things and do not capture others, nonetheless they show a couple of things.

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One is that Medicare tends to track sometimes with a lag what is happening in the rest of the economy, but Medicare does not do worse than private health insurance so again the folks who have the faith based belief in the private sector as opposed to the public sector can't count of that as the major source of savings for the Medicare program.

Indeed, sometimes Medicare does very well and serves as the lead for the private sector. For example, some of the payment systems that Tom talked about have been very innovative and started with the Medicare program. Moreover, Medicare's coverage decisions, for example, are often captured by private insurers and used for their coverage decisions as well.

So, what really is tracking the growth of Medicare spending and what should we think about in terms of these trends? And I think you can get a pretty good sense of that by looking at this chart, which essentially just shows you what Medicare's projected increases are and what all other health care's projected increases are.

They are pretty much on the same track. They are pretty much driven by the same things. Americans love our health care. We love our technology. We spend actively on it. We do not necessarily pay higher prices all the time, although our prices and incomes for example for professionals are higher than in other countries.

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But nonetheless most of health care tends to be driven by new technologies and use of services and often not even just use of switching from one type of service to another, but the additive use that it is not uncommon for example for people to start an x-ray and move up to a CAT scan and to an MRI, et cetera, but to do all of them, not just to do one instead of the others.

So, the problems of health care for Medicare are exactly the same problems that we are facing with the rest of the economy and we need to think about that when we talk about the ways in which we can solve some of those problems.

Now, some of the low hanging fruit has already been discussed and raised here and I think that is important to think about. For example certainly some of the payments, private plans and Medicare, some of the payments in the home health system, which have just been isolated by GAO and talked about as a problem, are areas where you can do some interventions that are Medicare only and save some costs.

But over the long run, year after year, it is going to be keeping the eye on the prize of all of health care, which is one reason why a lot of people are opposed to talking about entitlement reform all by itself as compared to health reform, for example, because there is a lot of overlap between the two.

Now, what about asking beneficiaries to pay more? I remember one of the times that I gave this talk was to a bunch

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of congressmen and senators at a retreat in Florida where we had a nice view of golf carts and people zooming around the golf course outside the window.

The problem was that those 65 year olds and above were not particularly representative of everyone else, and moreover what is important in terms of thinking about this is that the growth in burdens on seniors and other persons on the Medicare program, the persons with disabilities, will grow just as fast for the most part as the burdens that we find so unsustainable on tax payers so as a caution to keep in mind when we say well, just let the tax payers – I mean just take it off the tax payers and put it on to those beneficiaries because surely they are much better off.

If you think about these burdens, the current burdens on this chart are shown in blue are the per worker burden, that is the tax payer, what the tax payer is responsible for on a per worker basis and the red or sort of magenta I guess here is the per beneficiary burden, that is what individuals pay out of pocket, what they pay in income taxes, and for the few who work, those who pay payroll taxes, so it is capturing several things.

And that burden stays pretty much consistent in terms of the growth for both through 2020, although it goes a little bit faster for beneficiaries, and then by 2040 that is where you are seeing the impact of the baby boom generation causing

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per worker burdens to rise at that point faster than per beneficiary burdens, but nonetheless they still both grow. This is with no change in public policy.

And finally, as food for thought here, I think it is finally or maybe have one more, no, next to finally, the expected growth per capita in several statistics is worth noting as well.

Many seniors still rely primarily on or substantially on social security for their well being and between 2007 and 2030, the security benefits for those who retire at age 65 and these are two different sets of people, people who are retiring at 65 in 2007 and people like some of you retiring at 65 in 2030, would grow by 18-percent in real terms.

So if I had another one for current beneficiaries, it would largely be flat in real terms because this is adjusted by the CPI which causes social security benefits to go up, so you should think future beneficiaries will be better off, current beneficiaries will hold their own. Medicare costs born by tax payers will grow by 88-percent, but Medicare costs born by beneficiaries by 2030 will grow by 111-percent.

That is because the cost sharing that comes on the side of again B and D, which grow faster than A is greater and a bigger share of what people pay. They will be paying premiums that are consistent with that. They will also be paying income taxes out of which payment subsidies go up as well, and so we

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are talking about relative burdens here that are going to be very large, even with no change in policy, no increase in burden through policy on beneficiaries. So, it makes it hard to think about going too far in that direction.

Finally, the last thing in terms of food for thought, and this is getting to be very controversial these days. I have been reading some interesting things in *Health Affairs* that I would point you to that for a long time now. Winberg and his colleagues at Dartmouth have put out an atlas that shows Medicare spending per capita and in this case it is by hospital referral region and I think this is a very interesting chart because it shows there are enormous variations.

This is again fee for service because we don't really know how much for managed care plans, for Medicare Advantage plans, that is a giant black box, but what we know in this case is that the cost and the spending are very low. Those North Dakota farmers just don't spend a great deal on health care but those folks in Texas and Florida do and so one tempting thing is to say well, if we could just get everybody to the average, we would be better off. Not necessarily.

We do not know that the average is the right level. We do not know that whether North Dakota is the right level or whether Florida is the right level, although we suspect it is not, from some other studies that have been done.

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But in addition people are now beginning to ask how does this vary for other parts of the population? And if you look at a similar graft for Medicaid, you will find that Medicaid is often just the flip side of that, we are more generous in the Medicaid program in many states in the north and much less generous in Florida and Texas, for example, which makes you wonder whether all those people have saved up - and that is where uninsurance is also high, has saved up their expenditures.

That could have something to do with it, but there is a controversy now about what the quality is, how to measure the quality, that I think points out that we don’t have very good indicators as yet.

Nonetheless, the other thing that is troublesome about this is when you try to push on the health care spending balloon, remember that members of congress represent states and regions and districts and as a consequence something that is going to push down on that balloon harder in Texas than in North Dakota is going to be problematic for some people. and certainly if it pushes down in Montana for example where we have a prominent member of the senate, and Iowa and not elsewhere, you are going to have big time problems in terms of discussions.

It complicates the discussions. It is an interesting and important thing that needs further analysis and care but it

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is another complicating factor in trying to get our hands around this giant elephant called Medicare, but I would also leave you with just the thought that while there are no easy fixes, the good news is that for many years now Medicare has been a highly successful program.

It is well liked by its beneficiaries. It largely achieves universal coverage for some of the hardest to cover people in the United States, and does so at no less rate of growth than the rest of the health care system, so think about Medicare. It is big because it is on the budget and it is part of the federal government and we get very exercised about it but it is only part of our health care system, albeit a very important one. Thank you.

ED HOWARD, J.D.: Okay. I think we have really set up the opportunity now for you to ask almost any question you want about Medicare. I would urge you to keep your questions short, keep it fact based to the extent that you can, and if you come to the microphones identify yourself and your affiliation.

We have some difficulties with the webcast but we are now functional on that front as well and I would urge you if you are watching the webcast and would like to have a question asked, to go ahead and submit it by e-mail to info@allhealth.org and we will try to get it answered for you right here.

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Also, you have the green cards here in the room if you would like to have a question asked and don't want to maneuver, we are in a small room and we are packed pretty tightly and I appreciate your indulgence in that so we could accommodate as many people as we could, but if you don't want to have to crash to the microphone you can fill out the green cards and bring them forward.

Let me just ask one quick question if I can retrieve my notes. Juliette, you were talking about just in general a social insurance program and I know this is maybe even a primer to a primer but what do you mean by social insurance and why is it different from other programs?

JULIETTE CUBANSKI, Ph.D.: Well, so there are three major I would say social insurance programs that we think of are entitlement programs, Medicare, Medicaid, and social security.

Medicare is a health insurance program specifically and my reference earlier to it being different than Medicaid and private health insurance was that it covers everyone who is entitled regardless of their income, which differentiates it from Medicaid and it also covers people regardless of their health status which differentiates it from private health insurance where if you are an individual you can be denied coverage.

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So in its capacity as a social insurance program, it is a universal coverage program. It is a universal entitlement that we as a nation have agreed we will fund for people who are eligible and everybody who is eligible can receive those services.

ED HOWARD, J.D.: Very good, thank you. Diane, you have got some cards already. Why don't you delve into them?

DIANE ROWLAND, Sc.D.: Well, we have talked a little about technology and its role in rising health care costs at many of these forums and this question says could you please discuss how Medicare pays for new technologies and what reform efforts are being considered? Tom?

TOM GUSTAFSON, Ph.D.: Guess where this one goes? There are two basic answers to how Medicare pays at the moment. In most of its payment system, certainly most of the large and prominent ones that were on the slides earlier, Medicare changes the relative values, remember I spoke about those earlier, from time to time, usually year to year, in ways that reflect the introduction of new technology.

This is a fairly gradual process that takes at least three years for something to be recognized but it is fairly automatic. There are other provisions that are specifically aimed at specific items and new technology which are identified. There are provisions in the inpatient and outpatient hospital systems for those.

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They are of comparatively narrow focus and they look at new technologies which come along which offer the potential of providing a substantial improvement in the care delivered to Medicare beneficiaries and also have a substantially increased cost. So, those provisions allow additional payments to go to the providers using those technologies. It is important to recognize here Medicare pays providers. It does not pay manufacturers of technologies.

So, those situations have been in place for some period of time. There is a whole litany of issues that the advanced technology industries have been putting forth for some period of time including changes in the coding structure that would be used to identify these kinds of technologies, improvements in how coverage is determined and identified and improvements in the payment area as well. They go on for some length.

They have played – some of those kinds of things have happened. I expect we will see more of this kind of thing in the future. I think it is important to recognize just as a summary comment that Medicare pays regards to mission as facilitating the delivery of high quality care to its beneficiaries. That is different than paying for new technology.

In other words, it is paying not for the tools used but for the delivery of services and one important point is that for tools to fit well within the Medicare payment system, they

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need to demonstrate that they can do a good job in helping that delivery of care.

DIANE ROWLAND, Sc.D.: This question relates to health reform and Medicare, how could Medicare be used as a platform in health reform? How does it relate to the discussion going on about a public plan? Marilyn?

MARILYN MOON, Ph.D.: Sure I would be happy to talk about that for a minute. I think Medicare could play several roles. Clearly it could be the public plan that people think of sometimes as the fallback option. It could be limited as a fallback option for people of a certain age, for example 55 and above, for folks many of whom lose jobs or if retiree health coverage declines further in the future could be benefitted by that and it could also serve a role as a model for the rest of the health care system.

We are going to need to be exploring a number of areas of cost containment. We have heard discussions about electronic health records, about cost effectiveness or comparative effectiveness or just effectiveness research in some cases, and you could use those kinds of techniques in the Medicare program, introduce them and have Medicare essentially be a demonstration for that.

You could also do that with other things that Medicare currently does demonstrations on, although it is often hamstrung. If you have a good idea for a change in the

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delivery system, and you want to see innovations take place, it is probably not a very healthy way to do it to require that Medicare – that demonstration be budget neutral from day one for example. If you are going to invest in something in the beginning and see if it pays off in lower costs over time, then you pretty much limit what you can do if you really do have a demonstration that doesn't allow for any increased cost.

DIANE ROWLAND, Sc.D.: The next question relates to the Medicare Part D plan reimbursement, how are Part D plans reimbursed by Medicare? Is there a specific payment per patient in each region or do the plans get more money based on enrollee use? Juliette you want to handle that?

JULIETTE CUBANSKI, Ph.D.: I can speak to that and Tom I know you can probably pick up where I leave off or where I might get it wrong, plans bid just like in Medicare Advantage, plans bid. They submit bids for how much it will cost them to deliver services to each enrollee for the coverage that they want to offer.

And, it is a per capita fee that they would receive from the Medicare program and they also receive reinsurance if their costs are in excess of what they project at the outset so it is an advance bidding system and there are extra payments that are allowed to plans if their costs are excessive. I don't know if that covers it, Tom, or do you want to?

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TOM GUSTAFSON, Ph.D.: I think that is fine. You wind up with the Medicare – as a result of this bidding process, Medicare winds up paying the plans on average three quarters. The beneficiary premium comes in on average at one quarter. That allows a fair amount of choice. There are a ton of these plans out there. Beneficiaries have a lot of choice among them. One aspect on which they may want to choose is the premium that they would have to pay on a monthly basis.

It is also worth mentioning that a Part D plan is a cluster of drugs, that there are certain drugs that they all have to cover but beyond that they can pick and choose within certain limits so that it becomes important to beneficiaries to know which drugs they are on and how those will be paid for under the various plans. The Medicare program has introduced a set of tools that allow beneficiaries to assess that and the affect that may have on their individual situations.

ED HOWARD, J.D.: Can I just ask you to address specifically the question of whether the payment changes if the person uses a lot more drugs than they were expected to do? In other words, you get a payment from Medicare, $30 a month or $50 a month, but either prospectively or after the fact it turns out that the beneficiaries are using a lot more drugs than they were expecting to when they bid, do they get more money or not?

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JULIETTE CUBANSKI, Ph.D.: They get retrospective payments. There is a reconciliation process that happens between the government and plans after the plan year is over and so plans do, there is some compensation in place for plans that have extra high costs beyond what they projected they would have.

DIANE ROWLAND, Sc.D.: Tom, this is a question to follow up on one of your comments to explain the 2010 demonstration project, what were its origins, what is the goal, and what is the best case versus worst case scenario?
[Silence]

ED HOWARD, J.D.: If somebody wrote this question, I want to clarify what 2010 demonstration program we are talking about would be a lot easier for Tom to do that, or for Juliette. Tom volunteers.

JULIETTE CUBANSKI, Ph.D.: The only demonstration that I know of that is supposed to be 2010 is the Medicare Advantage demonstration and/or the DME demonstration so the question is which is which? The 2010 Medicare Advantage Demonstration, I haven't heard of for awhile so I don't know if it is even alive and well, so I have to admit that's one I'm out of date on.

TOM GUSTAFSON, Ph.D.: The DME Project that was on my slide earlier is not a demonstration program. It was based upon a demonstration program which showed folks that yes, you could do this without grave consequences and you could save

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about 20-percent in doing so, so that attracted congress' interest and they put that into place, but that will proceed on a regular program basis. It is ramping up but it's a little bit different.

DIANE ROWLAND, Sc.D.: This question relates to the SGR formula that we talked about for physicians and wonders what some of the proposals to replace the SGR have been or what's being proposed by the Obama Administration and how would those potentially work?

TOM GUSTAFSON, Ph.D.: I refer you to a nice fat book written by the congressional budget office which came out middle of December I think. It is an annual publication of theirs, full of dozens and dozens of ideas that congress might wish to consider in changing Medicare and other health care programs. And that volume includes some discussion of this issue.

The prominent idea there would be to disaggregate, to split apart the current SGR system and to do it on a more of a service line, so as it is at present, all physicians are lumped together in the same SGR. This is criticized because it's really hard for physicians to take into account their behavior in affecting the aggregate when they can't even see each other, so you need to have that kind of a budgeting system be effective.

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You need to have a group that can get together and understand that the behavior of one, when aggregated across everybody, is going to affect the whole, so the way of addressing that or a way of addressing that, that CBO has put forth, would be to split this apart, to have primary care for instance as one element that would be looked at, surgery another, imaging might be a third because that's been a source of particular concern.

That is CBO's idea. The administration's proposal, I am not recalling seeing a lot of detail on that as yet. I think they have put forth this as part of what they are dealing with in terms of something called a reserve fund, so they are trying to make money available to fix the problem. Fixing the problem is hugely expensive.

In order to stop a 20-percent payment rate decrease, it is going to cost a lot of money, particularly since it goes out over a number of years, but I don't recall them as yet specifying a particular proposal in that area but of course they are not done with their budget picture yet. They have presented what is basically an outline, you know, 100 page book not a 1,000 page book we are all used to looking for.

MARILYN MOON, Ph.D.: I would just add that I think one of the interesting things about the SGR is in a sense it was an attempt to have a budget, a universal budget for in this case only a little part of health care spending, that is Medicare

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physician spending, so when people say we should have a budget cap that says we are going to spend no more than $2.6 trillion a year, whatever, this is what you get.

If it doesn't happen, then you either ratchet down what you pay to people or you do what Germany does for example and all the docs go on vacation in December, or there are other ways in which you do it, but it is I think a good illustration of how tough it is sometimes to hold the line. The GZP portion of this was an attempt to say health care spending shouldn't be rising faster than GDP, and that is one of the main reasons why we get where we get.

PAUL BACHER: Hi. Paul Bacher from the office of Congressman John Larsen, I've heard a couple of panelists say how successful Medicare has been, and I guess one of the metrics is that it covers people but I am wondering how do we talk about success in terms of keeping seniors healthy? Is there or has there been comparisons of the way other highly developed countries take care of their seniors to see if there are other means of keeping them healthy? So, I just wondered if you could talk about how Medicare keeps them healthy/

MARILYN MOON, Ph.D.: Interestingly, it is very difficult to compare Medicare with seniors in other countries because it's a similar kind of system in other countries. It is more probably telling to compare the under 65 population to what other countries show, but the length, the increase in life

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expectancy in the United States has been much faster at 65 and above than it has been for the rest of the population for all the years that Medicare has been in place and in general Medicare in the United States at age 65 compares favorably with other countries where we lag behind them substantially in other mortality statistics.

JULIETTE CUBANSKI, Ph.D.: Can I just add, in terms of benefits as well, Medicare has recently expanded its coverage of preventive services. There is a welcome to Medicare physical that people who come on to Medicare are entitled to receive so they are recognizing the delivery of good medical care involves delivery of preventive services as well.

DIANE ROWLAND, Sc.D.: You could also add that Medicare inherits uninsured patients who delay their care until they actually get onto Medicare, so one of the big bumps that we see in Medicare spending is for people newly enrolled who have previously delayed in getting their care, so that is another link between Medicare and health reform.

CHRISTIE SCHMITT: We also know the prevention that happens in that 55 to 65 age population actually winds up saving Medicare money, particularly colorectal cancer screening and I am Christie Schmitt from the American Cancer Society which is why I used that as an example, our cancer action network.

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And I would like to ask the panelists, building on some of the comments already that have been made, to comment on the role of Medicare, given its magnitude in setting overall standards of care and patterns of care and to your question, how we measure how well we are doing in this country and use the example of cancer.

And what I have been told is very tasteful goldenrod, on the left hand side of your packets is a series of four charts that are just coming out, just came out today, and the Medicare and cancer chart as well will help you answer constituent questions is going to be on the Alliance's website as well as ACScan.org.

And so when you think about the magnitude of changes that can happen in Medicare, to answer the question why would we care from a cancer perspective is that Medicare currently pays for 45-percent of all cancer care in the nation so when things change in Medicare, things are going to change for cancer care, and for the under 65 population as well.

Now why should Medicare care about us, people who have had cancer or everybody – most people are going to get cancer, is that almost 1 in 10 Medicare dollars are spent on cancer care, and a cancer beneficiary with cancer costs three and a half times what a beneficiary costs without cancer, and going to catastrophic caps, stop loss, patients with breast cancer for example pay 20-percent of their cancer costs and that is on

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a base of about $30,000 so you can do the math and see what kinds of things are happening.

But going back to the thing I would like you to comment on is thinking about the magnitude of Medicare's presence in paying for and setting standards for certain diseases, what do you see is the future of Medicare in sorting that out?

MARILYN MOON, Ph.D.: I was very glad to see the Obama Administration asking for more research funds for CMS, not just because I'm a researcher, but also because there have not been substantial amounts of dollars available for doing research. And I think that one of the good things that you have with the Medicare program that we don't have currently easily accessible is a wealth of administrative data to do the kinds of chart books and so forth that you have but it also allows people to dig deeper into a lot of these issues that are relevant for the population as a whole.

And I think looking at specific diseases, looking at specific types of treatment, looking at episodes of care and so forth, are all things that are going to be important for people to understand. We are going to be grasping a little bit at straws for awhile to find easy cost containment activities and I think that there is a lot that could be done in that regard.

MICHAEL DANUS: My name is Michael Danus. I was wondering as the public awaits the administration's nomination of the next CMS administrator what qualities you could comment

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on that the next administrator should have, especially with health care reform being on the forefront and these challenges laying before us?

ED HOWARD, J.D.: Let's hope the administrator is not in the audience. [Laughter] Didn't need a Medicare 101 briefing. [Laughter]

TOM GUSTAFSON, Ph.D.: I spent a lot of time talking to administrators at different times and I think it's really important to recognize that although this is not a cabinet level job, it is absolutely one of the most important jobs in Washington, so it's hard to imagine one that is going to have more of an impact in the health care sector generally. Possibly the commissioner of FDA has already been announced. So, it's big league here, no question about it.

I think it's going to be interesting to see what the administration's choice is on this, partly because of one of the aspects of what you described a moment ago, to what extent are they counting on the administrator of CMS to be a leading force in health care reform versus a leading person running the existing programs and dealing with the necessary reforms in those programs.

The latter is a full time job all by itself, and when I spoke earlier about the 12 different payment systems, most of those require the processing of two regulations a year. I noticed a proposed rule making it a final, and the

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administrative burden of dealing with just that portion of the world, of running the Medicaid program, et cetera, is very high.

So, one of the requisites, if I were in the position of advising the president and he has not called me to ask, [laughter] but one of the things I would want to make sure is the senior management team at CMS had some folks in there who are going to know how to keep the trains running and how to build better trains within that program. At the same time, they are paying attention to how these programs fit within whatever is going on in the health care reform environment.

MARILYN MOON, Ph.D.: I would just add that I totally agree with Tom. I think it is very important to pay attention to CMS and not have it be just the secondary thing as part of health care reform. Medicare and Medicaid have been managed by CMS for many years, getting more and more complicated with fewer and fewer resources in essence and in particular I think some of the attention to the consumer issues, the beneficiary issues, in an era where we ask people to be more responsible for their health care needs a lot of attention.

So I would hope there is a lot done on the care and feeding of CMS, whether it is a very active deputy or a very active CMS administrator. Probably you really need both, but at the very least I think there needs to be recognition of the need for a lot of attention to these programs.

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ED HOWARD, J.D.: Could I just ask, as we have a pause here, that I neglected to mention before the presence of the ubiquitous blue evaluation form in your kits on the left hand side, if you would as we move into these last minutes of the Q&A, make sure that you take the opportunity to fill that form out and help us improve these briefings for you. Okay, Diane?

DIANE ROWLAND, Sc.D.: Among some of the payment issues we have, we have a number of questions about price negotiation for pharmaceuticals and why the government has not been able to do that, why CBO has not given that a score as a cost saving measure, and just another question to explain what it even is and why it isn't happening, so Tom, three questions at once here.

TOM GUSTAFSON, Ph.D.: I am not sure I heard all of them but let me – selective hearing on my part. When this chunk of the statute went into place, the understanding of congress was that Medicare was not going to be directly involved in these price negotiations and that has been a bone of contention between democratic and republican interests ever since.

This was an item that was prominent on the agenda of the house democrats at least when they took over that chamber three years ago, two years ago, whenever that was, but it was not pursued in that congress.

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So, it is coming back again partly as a result of campaign attention to all of this, but perhaps because I spent time while this was being implemented in the agency I may have a little bit of a biased view on this for which I apologize, but the view I have is that you have to pay some really close attention to what is likely to happen, how is CMS likely to go about it, if you give them the ability to negotiate?

The plus of negotiation is supposedly that you've got a very large caseload where Medicare could swing that caseload all at once and bargain for reduced prices in an effective way. On the other hand, to make that a realistic concern, a realistic element in negotiation, Medicare would have to have the willingness to say okay, we are just not going to cover this set of drugs over here because it is being offered by the company we decided not to do business with, and that is a concern when you are operating a national program. You would no longer have the same degree of choice that is available.

You then have to also look at the administration of this. CMS has no capacity to do this task. They have nobody over there who knows how to do it. Maybe not nobody, but two or three people who have been brought in, it's not something they have ever done before.

So, if you were to give this job to them, they would do what? They would hire contractors to help them do it, which would be let's see, pharmacy benefit manufacturers, and so you

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go around the barn and get back to where you are today and it's not clear you have won much in the process. I'm sure there are other points of view on this but I think one needs to look at least those kinds of concerns.

MARILYN MOON, Ph.D.: I think it's also very hard to imagine how you make that work in the current structure. What is the role then of private plans if they are not negotiating for price or they are not being able to choose the drugs?

So in a sense it is kind of antithetical to the whole idea and so it's very – I agree with Tom that it's very hard to imagine how you make that work unless for example you had a Medicare fallback plan that was a government plan and that was sort of the model for being very tough on all these things and pushing in that way.

ED HOWARD, J.D.: There is statutory authority for Medicare to operate a fallback plan, is that right, that hasn't been activated because private plans have filled all the jurisdictions?

MARILYN MOON, Ph.D.: I think it was only allowed if there were not enough plans and that has not been the problem.

DIANE ROWLAND, Sc.D.: This is a pretty simple question to start with. Can you discuss Medicare Part A, 80/20 rule?

TOM GUSTAFSON, Ph.D.: Everything in life has an 80/20 rule. [Laughter] Eighty percent of your attention is taken up of 20-percent of your issues, so what are we referring to here?

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You don't have the same deductible structure you do in Part B, which is the 20-percent, I'm sorry, excuse me, I'm thinking coinsurance, copayment structure, Part B has a 20-percent copayment, so I'm a little bit lost to know exactly what is being purchased.

JULIETTE CUBANSKI, Ph.D.: That would be my guess is that the Part A reference was perhaps meant to be a Part B reference? In which case, as Tom said, there is an 80/20 coinsurance split on the original Medicare fee for service side, Medicare picking up 80-percent and the beneficiary picking up 20-percent of the cost of services.

ED HOWARD, J.D.: And if someone who wrote that question wants to clarify what the Part A 80/20 rule is, they should feel free to repair to the microphone and clarify.

BOB GRIST: Bob Grist with the Institute of Social Medicine and Community Health, we are talking about the Medicare program, which is one sector of the health care system, and yet it's a very important sector because it represents 45-percent of the hospital revenues.

But we also heard that DRGs are not reflective of the actual costs for a particular hospital or for the charges that hospital has for the services that they provide. These are diagnostic related groups that represent average resource uses, I understand, from what I have heard today.

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What I am curious about are the ways we can increase the efficiency of the health care delivery in the geographical areas around the country, you know, where all those Medicare hospitals are located, and whether there is potential leverage in Medicare policy for getting hospitals to relate to the health care delivery system in which they are located in more efficient, effective, and equitable ways, in other words, recognizing that Medicare is a public policy lever, probably the most significant federal policy lever.

Instead of thinking of Medicare just as a model program that other programs are competing with, is there a way of learning from the administrative experience of the Medicare program and applying that experience to making health care delivery systems function more efficiently, effectively, and equitably at a geographical level.

That is different from saying a public health plan option that private plans are competing with, but I am trying to get back to the days of planning, health care planning, where we try to look for ways of addressing inequities in delivery systems, not just relying on a DRG but looking specifically at the needs, different needs in different communities.

I am wondering if there isn't leverage in Medicare, in the Medicare program to address that kind of comprehensive health care reform challenge.

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ED HOWARD, J.D.: Good question. Marilyn?

MARILYN MOON, Ph.D.: I think the way in which one would start to do that would be to look for example at ways of coordinating the hospital, home health and skilled nursing benefit and thinking about ways of coordinating that better and I think that makes a lot of sense. The siloing makes it very difficult to do that and makes a lot of entities very reluctant to do so, but we also have integrated health care systems out there in certain parts of the country who might be willing to take that on as a demonstration for example.

I am thinking and I don't want to volunteer them, but the Geisinger Health Care System in Pennsylvania where a lot of their work is done in an integrated environment and not always with just HMOs. They have an HMO but they also treat fee for service Medicare patients and they might be willing to think about that.

I think the medical home issue is another area where that makes some sense and a medical home makes a lot of sense but only if we do it right and I am concerned that we are not going to do it right, we are just going to play with the payment system and hope that doctors who do more, get more.

And of course the ultimate problem right now of the siloing is Part D, because anything that is done in Part D that reduces hospitalization for example, with better adherence and compliance with drug regimens, costs Part D provider more and

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doesn’t show up anywhere else in terms of the system of rewarding anyone.

So my sense is that we would have to really start to think about some fairly assertive and aggressive demonstrations. I think that would be a good idea but we have to come back and really rethink a lot about how the demonstration process has worked in Medicare up to this point.

ED HOWARD, J.D.: Are we not talking about some sort of demonstration of bundling of payments? There is certainly a lot of talk about that as a payment improvement technique, which presumably would get at some of what you were talking about.

MARILYN MOON, Ph.D.: Yeah those are the kinds of smaller ones, but those are always easier when you say for example bundling physician services or bundling with a physician in the hospital for one particular treatment. The difficulty is when you start to talk about a more broad based system where you are trying to not develop 7,000 more codes but rather kind of clump these things together that are dispirit and that is tough.

DIANE ROWLAND, Sc.D.: This is going to be an interesting question to have the panel answer, from all of our discussion I think we have convinced some of those in the audience that Medicare is an overly complex program so this

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question is what do you think are the pros and cons of stopping Medicare and restarting with a newly designed system?

JULIETTE CUBANSKI, Ph.D.: Marilyn you can take that one. [Laughter]

MARILYN MOON, Ph.D.: I think that you should not throw the baby out with the bath water. I think that there are opportunities however if we talk about substantial health care reform to change Medicare. One way in which we could change Medicare for example was do away with A and B. It made sense 45 years ago. It doesn't make sense now. And you would have to do some things to protect some folks for various technical reasons.

I think we could also integrate D back into the program, even if you have kept some private insurers, one of the questions is the opt out versus opt in approach. Part B is wildly successful because they just assume you are going to get Part B unless you do something. Part D you have to jump through a lot more hoops to get it.

Finally, improving the benefits enough so that they would look like a good basic health care plan that would be similar to what would be provided to the under 65 population and that would largely deal with fixing the deductibles which are beginning to look like a high deductible plan because Part A is so high and there is no upper bound limit.

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You could do those things and make Medicare look a whole lot more like any basic health care plan that would be competing out there without having to start all over again because one thing I do know is look at the people who switch during open season who have chosen to go into D and C, people don't like making new choices.

They don't like moving around, even if their current system isn't working very well for them, they figured it out, they're going with it, they're sticking with it, and we are not seeing a lot of switching around.

DIANE ROWLAND, Sc.D.: This question relates to the Medicare population's contribution if they are higher income to the cost of the program and raises the issue of that is based today on income, shouldn't we look at potentially means testing Medicare using both income and assets as many of the elderly have higher assets, so this is an issue that has come up and I know Marilyn you have done research on this.

MARILYN MOON, Ph.D.: It is a myth that people with low income have hidden away large amounts of assets. If you talk about people at 150-percent of the poverty level, which is about $16,000 or $17,000 for a single individual, it is highly unlikely that they have squirreled away a lot of money. Now most of us used to have some money we squirreled away in our 401Ks which are now sort of 201Ks I guess, but you then imagine that you should be spreading that out over the next 20 years of

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your life or whatever. If you do that, even with substantial assets, it doesn't add that much per year.

So, I am skeptical of going very far down this road of means testing. You don't end up for the most part losing lots of folks. The difficulty is until we make this a very middle income means tested program, we are not going to save much money because there just are not enough 100,000 errors out there who are seniors and persons with disabilities to make it worth our while.

It is expensive to test for that. It is problematic. We are moving away from that, I hope, as a society, and again if you have got $50,000 worth of assets and you want to go after a 65 year old lady who is living on $10,000 a year, more power to you, but you are not going to find me enthusiastic about that. Or even a lady who is making $60,000 a year, and living on that in the United States, so I am a big skeptic of that. I don't think there is anything wrong with talking about income relating but never fool yourself that it's going to save a lot of money.

DIANE ROWLAND, Sc.D.: I think it's also worth clarifying, since this isn't Medicaid 101 but a lot of the experience with assets has come from Medicaid which does have an asset test for the adult population that there your house is generally excluded because if you are living in it, it would be very hard for you to use that as an asset, so that most of the

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elderly who do have an asset have that in the form of their home which isn't something you would want to take away from them to enable them to continue on medical care with Medicare.

The second thing I think is important when you talk about assets is that it adds an incredible administrative burden to the program and so the Medicaid program has been going in the other direction of eliminating the asset test because of both the documentation responsibilities as well as the administrative burden and they find very few people slip through that gate anyway.

ED HOWARD, J.D.: Let me just add one other thing, from my days as an aging person, as opposed to today when I'm just an aging person, [laughter] I remember that people over 65 had incomes below twice the poverty line at a rate of 40-percent. And I noticed in going through the background materials that are in the packets that has now crept up to 48-percent of all people over 65, even at 40 it was tied with kids for the highest proportion of any age group, with incomes below 200-percent of poverty.

People over 65 are kept out of poverty in large part by social security so there is I think a myth also about the rich elderly which if I can infer correctly from the trend is less of a question that it was before. Juliette?

JULIETTE CUBANSKI, Ph.D.: That is a really important point to emphasize. In fact, as I said earlier the Part B

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premium is indexed to increase with income and it's currently $85,000 for an individual so if your income is $85,000 or more, you pay a higher monthly Part B premium but I think the estimates are only about 4-percent of all Medicare beneficiaries have incomes $85,000 or more so it is a very small share of the Medicare population.

And as Ed said, many people are kept out of poverty because Medicare helps to cover their medical care expenses and I think that is a very important point to emphasize so for people who might be looking to income relating or means testing, as Marilyn said there is certainly not a lot of money to be found here and it is just hurting more and more people on the Medicare program if you move in that direction.

MARILYN MOON, Ph.D.: The other thing I would add is think about when we are talking about protection for low income families who are under 65 and people are talking about 200-percent of poverty, 250-percent of poverty, the most generous protection for Medicare beneficiaries through the Medicare program is 150-percent of poverty.

That is ridiculous, given the fact that seniors pay so much more out of pocket than anybody else in any other age group, and we have not improved upon that for years and years. So as incomes rise, modestly over time but not very fast for this population, their health care expenditure is rising very

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rapidly and we have got a lot of people between 150 and 200-percent of poverty who are in great difficulty.

So when I was talking before about using Medicare as a model or morphing Medicare into other kinds of health insurance reform, that is something that ought to also be on the table.

DIANE ROWLAND, Sc.D.: As we go forward with health reform, one of the issues that comes up is something called buying into Medicare for the people between 55 and 64, and so this questioner wants to just know what does that mean and how would it work?

TOM GUSTAFSON, Ph.D.: I'll try. You have a program in existence for folks over 65 plus about five million individuals who are disabled. That is your population at present. Notwithstanding, it gets kicked around a lot. It actually works pretty well. It provides a fair degree of reasonable coverage for a lot of people.

And so it is held up by some advocates as an example that could be built upon and if you are interested in a federal program that could provide care for an important component of the uninsured, well let's let people who are under 65 buy into that is the general notion, so that they would pay some premium.

I suppose it would depend a lot of the devils in the details here, pay a premium that would for instance cover 100-percent of their cost versus some smaller portion for elderly

people. Perhaps it is a premium that would be adjusted for income or have some subsidy component.

The program could accept those individuals without a lot of strain, you know, the capacity is there. It wouldn't require any major overhaul of the design of the program in order to do that. And so some folks have talked about well let's take the next slug of people, let's get the next decade of the aged cohort and at least make it available to them on a voluntary buy in kind of basis and I am sure that people have that in mind, at least some of them are interested in well, if we get that bite, let's go farther down below that in the future perhaps. That is the basic concept.

MARILYN MOON, Ph.D.: I think though the difficulty with that is that is that unless you reform the private insurance system, this is a make private individual insurers' rich act because you would get the worst risks that are turned down by private insurance which is a very broken market at the moment on the individual market, so you would want to have some way of dealing with that and that makes it much more complicated.

DIANE ROWLAND, Sc.D.: I am going to ask the final gap question about health reform and Medicare and that someone would like an explanation of the disability waiting period and how that can be addressed potentially in health reform or in Medicare reform.

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JULIETTE CUBANSKI, Ph.D.: Currently people who qualify for disabilities by social security administration, that entitles them to Medicare coverage but they must wait 24 months before their Medicare coverage begins, so that is the disability waiting period.

After the 24 months is over, then their Medicare coverage kicks in and there have been some proposals to phase out the waiting period and bring people on to Medicare sooner than the expiration of 24 months. I am not sure of the status of those proposals exactly but that could be one way of getting a small but really a rather expensive but a vulnerable population of people into a health insurance system that currently serves them but only after they wait 24 months.

DIANE ROWLAND, Sc.D.: I think that we have marched you through a lot of the Medicare program. I think one other thing that maybe didn't come out as strongly as we should have put it on the table today is that one of the other reasons Medicare is expensive is because it takes care of some of the sickest and individuals with the greatest health needs.

And that as Ed and I sit here and age, we know that as you age, you tend to have more health care needs and especially the coverage of the population that we just talked about with disabilities who tend to both be very high users of medical care and also high users of long term care, which remains outside of the scope of the Medicare benefit package.

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ED HOWARD, J.D.: Clearly some people age more gracefully than others. [Laughter] Let me just remind you to fill out an evaluation form. I don't have any final policy words for you. I will tell you that particularly you folks who are watching the webcast and may have a little bit of it scrambled or gotten onto it late that the archived version of the webcast will be available tomorrow morning at 10 o'clock on kaisernetwork.org and we will have the transcript in just a few days.

One other thing, if I can do a little commercial, you will find in your e-mail inboxes when you get back an announcement of a briefing we are running on Friday that actually may build on some of the foundation that we have heard today and that is a look at payment reform strategies in health reform and we will have among other people Stuart Gutterman who helped shape some of CMS' policies and Nancy Neilson who is president of the American Medical Association who has some difficulties with being bundled in various proposals, so feel free to sign up for that when you get back.

Let me just thank The Kaiser Family Foundation for its involvement and cosponsorship in this program, along with Diane's leadership. I particularly want to thank Lindsey Cook on our staff for whom this is the first briefing she has taken the policy lead and Tricia Newman on the foundation staff who has helped us shape this program from her position as an

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eminent expert in Medicare policy, and ask you to join me in thanking our panelists for an incredibly good discussion today.

[Applause]

[END RECORDING]

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