THE BROOKINGS INSTITUTION

CONTROLLING MEDICARE COSTS: IS PREMIUM SUPPORT THE ANSWER?

Washington, D.C.

Friday, December 16, 2011

Welcome:

RON HASKINS
Senior Fellow and Co-Director, Center on Children and Families
The Brookings Institution

OVERVIEW OF DOMENICI-RIVLIN PLAN:

SENATOR PETE DOMENICI
Senior Fellow and Co-Chair, Debt Reduction Task Force
Bipartisan Policy Center

ALICE RIVLIN
Senior Fellow, The Brookings Institution

Moderator:

ISABEL SAWHILL
Senior Fellow and Co-Director, Center on Children and Families
The Brookings Institution

Panelists:

HENRY AARON
Senior Fellow, The Brookings Institution

STUART BUTLER
Director, Center for Policy Innovation, Heritage Foundation

JAMES CAPRETTA
Fellow, Ethics and Public Policy Center

JUDITH FEDER
Professor, Georgetown Public Policy Institute

DOUGLAS HOLTZ-EAKIN
President, DHE Consulting

PAUL VAN DE WATER
Senior Fellow, Center on Budget and Policy Priorities

* * * * *

P R O C E E D I N G S

MR. HASKINS: Welcome to Brookings. My name is Ron Haskins. I'm a Senior Fellow here, and along with my colleague Belle Sawhill whom you'll meet in a few minutes, we run an organization here called the Center on Children and Families and part of the Center on Children and Families is a project called Budgeting for National Priorities and for a long time, 7 years I think, we have been trying to sound the alarm that the nation has a deficit and we ought to do something about it. We've participated in several activities one of which we call our Fiscal Seminar, the Heritage/Brookings Fiscal Seminar. It's 16 people with a lot of experience in Washington, Washington insiders as they refer to them in the *Post*, and for quite some time now we've been very interested in premium support. Here's why. Let me put two facts on the table that I think everybody in the room accepts and we'll all start with a common understanding. Number one, American is going bankrupt. Number two, health spending is a big part of our problems with financing. So if we're going to do something about America's deficit, we have to do something about health care, and in particular Medicare and Medicaid.

This idea of premium support has come to the top. It's gotten a lot of attention in the last several years. Attention was boosted yesterday as I'm sure we'll get into before this event is over because Ron Wyden and Paul Ryan agreed to something like a plan. There seems to be some debate about exactly what it is they've agreed to. And the answer is you never know until you see legislation and he specifically said we're not going to draft a bill so that there will be lots of questions I'm sure.

Because -- premium support and it seems to be a potential to reduce medical spending in general in the United States including Medicare and Medicaid, our fiscal seminar has pursued this. We wrote a paper. We got the best critics and the best supporters to write parts of the paper and it's very clearly distinguished who agrees and who doesn't. And we're following exactly the same format in this meeting this morning. We'll begin with a specific plan which is also outlined as the final part of our paper and is available to everybody here and will also be available on the web. Of course we were totally unbiased in our selection of the Rivlin-Domenici Plan. You wouldn't think that we'd by such a coincidence have a person from Brookings that sponsors the plan, but there it is.

So we're going to start with them describing their plan. Then I'm going to ask them a couple of questions, we're going to give you a chance to ask them a couple of questions. Then we're going to have a panel, and as in the paper, the panelists have been divided between people who support and people who don't so that you're going to get all of the sides. It's not Brookings or our budgeting for national priorities place to lobby for anything, but we are attempting to improve the understanding of the public and of scholars and of people who are interested in health policy and in the budget deficit, and in our wildest imagination we might even think that we could improve the understanding of policymakers. Wouldn't that be good?

Let's begin. Let me say just a few brief words about our first two participants. Senator Domenici of course is well known and has had a long and distinguished career especially focused on budget issues. He was a wonderful Chairman of the Senate Budget Committee, and when he left Congress he along with others started the Bipartisan Policy Center and he is now a Senior Fellow

there. And last year as many of you know, Senator Domenici along with Alice Rivlin authored a very good plan to address the whole budget, not just health care, but the entire budget. It's gotten a lot of attention. So Alice and Senator Domenici are used to working together.

Then of course we have Alice Rivlin, a Senior Fellow here at Brookings. Alice has had some experience in these matters. Alice was the head of the Congressional Budget Office. She was the first head of the Congressional Budget Office. She also was the head of the Office of Management and Budget. She has been on the Federal Reserve Board. And some of you may remember that back in the day she literally rescued the District of Columbia from the exact same budget fate that we appear to be facing now as a nation, that plan actually worked and ever since the District has lived within its budget so that that is an amazing accomplishment. So we have a great first panel and I believe Senator Domenici is going to speak first. Senator?

SENATOR DOMENICI: Thank you very much. First, excuse me voice. As I was joking with my friends, I said I went to the doctor to get cured from a little tiny noise that was in my throat and he put something down there and looked around with a light and told me that my voice box was not quite working properly and he sent me home with -- send me a note, somebody might help me. And here the next day I woke up like this and I can't get in to see the doctor. Instead of helping, everything has gotten worse. But anyway let's hope it will come out all right.

First I want to say to the Brookings organizers for Pete Domenici, this is the worst setting you could have because I usually have things about here and now I don't know how to read my speech. I have no classes and they're

terrific. Cataracts have been removed. I'm getting so old, I'm really burdening that Medicare system with costs. I know what it costs to be old and sick because I see those bills that Medicare gets. But I would like to tell you that the first thing that happened, we had the super committee appointed with the supermen on it, men and women, and they set about in a boat to rescue our ship of state and after all the time they had they didn't solve anything and the boat was floundering out there and they jumped overboard and each one had -- life preserver that said "I'm a D," had a D for a Democrat and an R for Republicans -- and they paddled ashore and the ship of state went out a little bit and then sunk. You know why I use it is because truly what happened is that those people weren't able to abandon their partisanness on taxes and on entitlements. They couldn't get rid of the thing that was on their back or R and D. And then that's what happened to America. The best changes -- all the problems went down in that boat.

So let me start by saying the problems -- while both parties may have come away unscathed from that one, America's economic and fiscal woes have not disappeared. They didn't go down with the ship. The economy is still sluggish and the central drivers of our debt went untouched. And Medicare and tax reform remain the cornerstones without any doubt, they are the cornerstones of fiscal reform. The plan that you're going to hear about today which is called Domenici-Rivlin, but to tell you the truth it should be probably be more Rivlin-Domenici because I'm not an expert at all and Alice keeps claiming she's not an expert and she knows 10 times more than I, so that tells you where each of us are.

MS. RIVLIN: Don't you believe it.

SENATOR DOMENICI: Fundamentally, Medicare reform has to take place and the costs that are currently being produced by Medicare have to be changed. And I'll just for a moment here and have you look at this chart. It is very easy now for anyone who knows this budget to say if you have a plan and it has not produced revenues and presumably revenues -- produced revenues and made us more competitive at the same time in the tax reform, and if you haven't solved some of the problems of health care led by Medicare, then you don't have a plan. And if you look up there at that one I put up for you, look at that blue line. That blue line is a graph of upward health care spending versus a percent of GDP. And we're measuring everything by a percent of GDP now, and look at that one. It looks like Social Security is there but it's not going to break this problem because the percent of GDP doesn't change much and neither does defense and domestic. Then go down and have all the other mandatory programs, and look at the one that's making the wrong kind of headway and it's this health care spending. It's going along that blue line, and unless you have a program that somewhere along the line, somewhere from 7 to 20 years, doesn't bend that curve, you don't have anything that's going to help America out of the mess we're in, out of the problem we're in.

The country has been presented with Simpson-Bowles which is a good plan. It doesn't have as much in it as we have in ours on Medicare, but it was a good plan on two-thirds of the budget. We had the other third, Medicare, and we're not embarrassed to tell you that we believe ours will work, that there will have to be a change from the -- regulate everything and it will work -- you can continue to regulate Medicare, but you've got to have something new for the new program and it would be competition, exchanges that will exist in the regions that

will bring competition into the program with a cap and that will be explained more by Alice as she talks about it. But it seems to me quite clear that a new approach is necessary. There are those who say let's just wait and rely upon the giant Obama health care program that's rocking along. We believe we have to find something new and what we have, it's new in the sense that we are promoting it and we put it together in a way that can be enforced, can be put on the table. But it's also quite obvious that there is a chance, some say a fifty-fifty or better chance, that the Obama health care plan will be declared unconstitutional. In either event, we are moving along with outs and it is not a regulatory scheme, it is a competitive scheme that would come into effect at a time certain. We do make sure in this competitive program that those who are poor and do not -- if they need money to help pay for their premium support, we provide for that in our proposal. Those who are not able to pay, they get a bonus and that's for the first time. We worked hard at figuring out how to do that and we think we've done that quite well in this bill.

So I want to say there are those who will say without question that ours and our proposal is not necessary, things are working very well with the implementation of the superbill, the Obama health care package, let it run its course. We say it's probably going to work if regulation works, but we think regulation hasn't worked in the past. We've got superinflation in spite of regulation and we ought to have this approach that we put forth for you and there for those who want to choose it. In the end, Medicare will not be taken off the table. It will still be there for those who want it. There will be a new program there, but those who want it -- and we think the combination of the two is the best thing America could do. With that I would yield to my colleague and say please

put this together so they'll understand something instead of having to rely on me. Thank you for listening.

MS. RIVLIN: Thank you very much, Pete. Why are we talking about Medicare reform? Why especially is the Center on Children and Families talking about Medicare reform? And as Ron pointed out, this is in the context of our enormous fear that the fiscal situation of the United States is unsustainable, we face a problem that threatens our economy and we have to do something about it. Our debt is rising faster than our economy can grow. And stabilizing the debt, our bipartisan commission found, Simpson-Bowles found, requires really two major things. One is slowing the growth of health care spending, especially Medicare. It would be nice to fix Social Security too. The other is raising more revenue from a simpler, fairer tax system.

Nobody we know wants to get rid of Medicare. Medicare serves a growing older population. It's an essential program. We can't do without it. We need to preserve it for the future. And as you look down the road, Medicare is not in good shape. The growth of Medicare is unsustainable in the long run partly because the current Medicare system, fee-for-service Medicare, does not reward cost saving or improvements in outcomes. It encourages a higher volume of services without looking at what you actually get for it. What to do about that? There are basically two approaches. One is a regulatory approaching, improving the efficiency and effectiveness of Medicare over time. The other is a competitive approach, letting alternative plans compete for Medicare beneficiaries. We're for both and this plan we believe put together by a bipartisan group should appeal to both Republicans and Democrats.

On making existing Medicare more efficient, we need to discourage higher costs. There are huge differences between different parts of the country in the cost of delivering the same services to the same patients with the same diagnosis. We need to figure out why that is true and adopt in Medicare the most cost-effective approaches to treating older people with, as Pete pointed out and as I know too, their multiple problems. In the Affordable Care Act we have a whole bunch of institutions, the pilot programs, innovative centers, the Independent Payments Advisory Board, that are directed to sift through the best knowledge that can be accumulated and get Medicare working more effectively and efficiently to hold down the increase in cost and we're enthusiastic about that general approach. The other approach is competition, let plans that will provide the same benefits compete in a way that incents them to be more cost-effective and to offer better services at lower cost. We are advocating that we move Medicare in that direction as well.

What would this plan do? We would preserve fee-for-service traditional Medicare not temporarily but permanently. If you want to be in that, you can stay in it. But we would provide the option of going to an exchange, a federally run exchange but we would set them up regionally meaning metropolitan areas and major rural areas would have separate exchanges. Plans would compete on those exchanges. They would have to offer the same benefits, at least the same benefits, as Medicare on an actuarial basis. They would be subject to the rules that they had to accept anybody who applied. The plan would be compensated on a risk-adjusted basis, more if you were older or sicker. And it would be a regulated exchange on which you couldn't cheat by

attracting the youngest and the healthiest patients in any way, that you'd have to play by the rules and you would be thrown off the exchange if you didn't.

The government's contribution would be determined by bidding on the exchanges in which fee-for-service Medicare would also be a competitor. The government's contribution would be the second-lowest bid and we believe that the competition would over time result in more cost-effectiveness and that fee-for-service Medicare if it improved as much as the regulators' approach hopes might well be the best plan in some parts of the country, maybe many parts of the country.

But we have a failsafe mechanism on the government's contribution. If the government's contribution determined by the bidding process were to rise cumulatively over time faster than the economy was growing plus 1 percent, it would be capped at that time and the excess would result in a means-tested premium. We would protect the low end of the distribution, but people with higher incomes would have to pay more. It is in that sense a defined contribution plan so that the Congress and the country would know how the maximum that Medicare would cost and, incidentally, that would make it scorable by our friends at CBO. If it turned out that a lot of cost was being shifted to seniors and if the Congress wanted to change the law, obviously they could. They could change the premium, take more out of providers, they could do anything they want. Congress can always change the law, but it would have to do it by legislation.

As Ron mentioned, yesterday Senator Wyden and Chairman Ryan came out with a plan which is quite similar. I think it's very exciting that a senior Democrat and a not-so-senior-but-emerging leader on the Republican side

have come together around a plan. We're going to need the solutions to be bipartisan and here is a step in that direction and we applaud it.

There is clearly no perfect answer to how to control health care costs best or how to reform Medicare best, but we think we have a compromise plan that should appeal to the hopes of those who want to reform Medicare largely by regulation, implementing best practice and so forth, and those who believe in competition. This is plan that puts together both of those things. Thank you.

SENATOR DOMENICI: Might I say before you move on it will be said today that we don't have any proof that this would work, but Alice has just explained that you could keep Medicare but you would have another approach available which she has described as competitive and regional. It seems to me that the problem that we have in this country is big enough in health care and its rising costs that we ought to try something different but at the same time not do it foolishly. If you keep Medicare and try something new, then obviously it will never be any worse than Medicare is because the approach is that would you like to have something else because it either provides better services or the price is better? We don't have to be total capitalists on the issue. I am a capitalist -- worried about America not being as free-enterprise-oriented as we were 15 years ago, but I don't think we're risking anything here and if we do have an approach that relies on something that has been very good for America and that is competition between A and B to provide or sell something so long as we have the last word up here as congresspeople and we'll leave that alone for a while, actually ours is a long-term solution, it's not next day or next week, it's long term, I believe it's worth looking at. And I want to close by saying you can't do better

than have the two, one Democrat and one Republican led by the Chairman of the Budget Committee in the House which has a commanding majority now, I don't know what they'll have in a while, and Senator Wyden who has been known in health care to be an innovator, to have the two of them working in the area that we are and coming up with something similar is to be very gratifying and it shows that hard work that we did and others did might prove beneficial to America's fiscal policy and our sick seniors as they pass through the system. Thank you again.

MR. HASKINS: When we look back, all the way back to when we first started out Budgeting for National Priorities, and now we look at the 7 years or so, there have already been some major events in this because when we started, hardly anybody was even paying attention, so a lot has happened.

MS. RIVLIN: Now they've noticed.

MR. HASKINS: Now they've noticed. I think we're going to look back at the Wyden-Ryan proposal as a crucial turning point in the event. First, do you agree with that? Then secondly, I think it would be very helpful and important in judging how important their plan is, if you want over very quickly the differences between their approach and your approach. I think it would be good to give the audience at least a feeling for how similar or dissimilar the plans are.

MS. RIVLIN: As I read the Wyden-Ryan plan, it is very similar to ours. Some of the language is a little unclear as is often untrue on Capitol Hill and they haven't written a bill. There are a couple of obvious differences. One is they start later. They don't start until 2022 which means that anybody who is 55 or older is not affected in any way, and they wanted to make that point. We

thought starting a little sooner would be a good idea because after all it gives seniors a choice, so why not give them the choice sooner?

SENATOR DOMENICI: That's right. And we keep Medicare while that choice is being --

MS. RIVLIN: You bet. I think that's the main difference. Wyden-Ryan also has a kind of appendage about employees of small businesses being allowed to take the employer contribution in cash, but that has nothing to do with Medicare. That's just tacked on. And I'm not clear that there are other differences.

MR. HASKINS: What about exchanges?

MS. RIVLIN: Exchanges. It's hard to say exactly what they are doing. They talk about competition and federal regulation of competition. They don't exactly say exchanges. We are more specific about that because we have a vision of exchanges set up around the country under CMS rules.

SENATOR DOMENICI: Let me say on exchanges it's interesting to note that under the President's health care plan, there are exchanges being developed also.

MS. RIVLIN: Right. Right.

SENATOR DOMENICI: So it's not like the only ones who trust in the market or want to trust it as part of the delivery system, not in total, but they do.

MS. RIVLIN: Indeed, from a long-run perspective, if you do believe that the exchanges under the Affordable Care Act will work and I think there's good hope of that, then you would have a population of people retiring who were used to exchanges and used to choices and you would have plans that

-- used to offering a plan on an exchange and they would want to keep their members in the same plan as they transition to Medicare, but that's a long way from now.

MR. HASKINS: As our fiscal seminar of these last several months went through this process, we heard a lot about the problems with premium support and there was a very powerful summary of those problems and the expiration of the problems in the paper written by Henry Aaron, whom you will hear from in just a minute.

In having going through those, the one that I think really resonates and something that has to be addressed, is that the elderly already pay something like 16 percent of their income for various out-of-pocket expenses for health care. And under your plan, any premium support plan, there's some risk that if the competition and the regulation from the President, so on and so forth, does not control health care costs, that some of the burden could fall on recipients. How do you respond to that when people bring that up as a criticism?

MS. RIVLIN: Yes, there is some risk and the alternative to that is saying none of it will ever fall on recipients, even high-income recipients. It will all fall on providers. That is basically what the Affordable Care Act seems to say, because it does have the same cap in it. It isn't exactly a cap, but the same goal for controlling Medicare costs, but enforced by keeping provider payments down. Not clear to me that that's absolutely the right way to go.

MR. HASKINS: And in your --

MR. DOMENICI: Could I say --

MR. HASKINS: Yeah.

MR. DOMENICI: Look, this whole problem that we're having, and

your seminars are dealing with in terms of fiscal responsibility, it's filled with risks. I mean, there's a risk that we're going to go bankrupt if we don't fix Medicare. There's no doubt about it. The seniors in this country want America to succeed. They don't want -- they don't like what they feel about America in the doldrums and we can't do anything.

And there is a risk that our providers won't be receiving enough money and we won't get the kind of medical skills applied to keeping seniors healthy. So we have to build a system that provides -- that the risk is shared. We want the providers to be paid well so we will grow and have the best in the world for our people. But there's no assurance that's going to happen unless we have a well-defined system. The costs are not going to shift on the seniors in any unreasonable manner. Nobody is going to sit around and let that happen. As you look at the cap, they're going to do something if that had happens.

So it seems to me, that -- what's going to happen is people are going to take our plan and go out to the public and say, no, it's no good because seniors might have to pay more, so throw it away. But the truth of the matter is everybody might have to pay more.

I mean, we might have to have taxes, too. Here's a Republican who's chairman of the Budget Committee says, fix health care and save money. And if that is not enough to fix our fiscal policy, go ahead and raise revenue. I have said that, but you've got to do both. You can't just do one.

MR. HASKINS: In addition, isn't it true that under your plan that there would be some protection for low-income elderly?

MR. DOMENICI: Absolutely.

MS. RIVLIN: Oh, yes, absolutely.

MR. HASKINS: I think that's --

MS. RIVLIN: And that's in Wyden-Ryan, too.

MR. HASKINS: Yeah, so that's an important point, that the criticism is somewhat addressed by protecting low-income elderly.

MS. RIVLIN: Yes, but the bottom line, as the senator has said, is the status quo is not an option and the costs are going to have to be restrained. And if they're not, they're shifted somewhere.

MR. HASKINS: Audience, please stand up, bring the microphone, say your name, and ask a question, not a long comment. We want to get in as many questions as we can. So let's go right to your right. Yeah, right here.

MR. FLEMING: I'm Chris Fleming from *Health Affairs* blog. I wonder if you see the history of Medicare Plus Choice as a little bit of a concern in terms of your plan. I mean, that program started out with a lot of the same goals for competition. Private plans were going to be paid less than fee-for-service and drive costs down through that competition. And over time we ended up with a situation where until recently, through lobbying and other means, the private plans were being paid, I think, something like 118 percent of fee-for-service. Do you worry that similar things might happen to your plan going forward?

MR. HASKINS: Good question.

MS. RIVLIN: Should I start on that? Yes, certainly the history of Medicare Plus Choice or Medicare Advantage does -- on the one hand, it's gotten -- the competition has gotten better and it's working. The competition in Medicare Advantage is working quite well in some places. But it wasn't set up right, we think. And there isn't an incentive to pick a more cost-effective plan

because it would save you, the beneficiary, money. The incentive is you might get more services, and you do. So we would change the way the competition is set up quite radically.

MR. DOMENICI: Where's our expert on that? Is he here? That would have helped us. We were at a point (inaudible) said, let's fix this.

SPEAKER: Paul?

MS. RIVLIN: Yeah, Paul Ginsburg helped us with this and might want to say a word about it.

MR. GINSBURG: Yeah, I would say the big difference is that by organizing private plans on an exchange, I think that you can get a much more competitive environment. Actually, I think the way the current political system is, the chance that private plans would be able to lobby to get more than the traditional is very slim. In fact, I think that the details of this plan actually make it pretty impossible because there is this very specific process that determines the federal contribution for a person's benefits whether their enrolled in traditional Medicare or a private plan.

MR. HASKINS: Paul, thank you. Next question. Behind you on the right. On your left now, if you can help us with this answer.

MR. ALTMAN: Hi, I'm Fred Altman and I applaud you. It seems to be going in an excellent direction. But any session I go to like this that discusses health care manpower said we need a lot more health care manpower. How are you going to control prices and increase the manpower?

MS. RIVLIN: I think we need different kinds of health manpower and that a competitive system is likely to incent that. If you look at the difference between us and other countries that -- other advanced countries that have health

care systems that deliver good health care for less money, or less percentage of their GDP, one of the big differences is they use more primary care and fewer specialists and they don't -- therefore, don't pay their docs as much. And the comprehensive plans that agree to treat you for what ails you tend to move in that direction faster than a fee-for-service system.

MR. HASKINS: All right. Let's take two questions and then we'll -- you have a choice of what you answer. Here on your right. Yes.

DR. POPLIN: Hi, I'm Dr. Caroline Poplin. I'm a primary care physician. What does your plan do about -- for example, the Mayo Clinic just bought two machines to do proton beam therapy for prostate cancer at $70,000 a pop. That's a treatment. The machines are terribly expensive. Well, now that Mayo has two of them, they're going to run them all the time. Are you going to have the insurance say, well, your plan just doesn't cover this? You need to get to Mayo before it buys the machines. Once it buys the machines, it has to run lots of people through them.

MR. HASKINS: Another question. Yes, right down -- yeah.

MS. MEREDITH: Hi, Diana Meredith from the House Budget Committee. I want to ask about risk adjustment. Everything I've read about these premium support proposals basically asserts that we will have some sort of perfect risk adjustment system that will control for all the cherry-picking that might otherwise occur. But everything I know about Medicare Advantage is that anything we do to adjust risk selection, they find ways to game it. So I would like to know, are there examples out there in the world of really well-functioning risk adjustment that give you confidence that you can design a system that doesn't result in a death spiral for traditional Medicare?

MS. RIVLIN: Risk -- we never said we had a perfect way of doing risk adjustment. Risk adjustment is difficult, the experience has been improving, and plans are doing it better than they used to. I think the way, as Paul said earlier, the way we would set up the exchanges would make it very difficult for plans to cherry-pick. They would have to take everybody. They would be prohibited from doing cherry-picking and that would be enforced. I mean, you have to have an enforcement mechanism. The Federal Employees Health Benefit Plan does police what the plans are doing, and you have to do that.

As to very high-cost treatments, you know, those are going to be a problem in the future. And as Henry Aaron has pointed out in a book some years ago, at some point we're going to get to rationing.

I think our point is, we're not there yet. And there's a lot that can be saved by doing things more cost effectively in the interim. So, let's do it.

MR. DOMENICI: Could I comment on the question on -- somebody asked about training enough people in the various expertise in health delivery. We don't have anything on that in our bill, but, obviously, the country has to be concerned about the adequacy of general practitioners in the like and something has to be done, not by way of the government taking over and deciding who's going to do what, but certainly we have to find a way to help fill those gap areas where there's more demand than we have professionals to fit the demand.

And there's no question, we have some of those in our system. And it's not resulting in just better service. In some instances, the doctors are getting the short end of the stick, and they don't take on more patients and don't fulfill their desires to the fullest.

I want to make a comment for fear that I won't get a chance. In working on this problem, I have, as an individual citizen, had the opportunity because of things happening to me that required medical care to meet perhaps 40 or 50 people involved in the delivery of health care, from the very best surgeon to the person that helps you get dressed if you're feeling bad. And actually, there is a tremendous positive attitude among those that are delivering health care, especially those that are graduates of our medical schools, that they have gone through an experience that makes them kind of automatically knowledgeable. But they are extremely aware of the patient and of what they're doing for -- are they doing the right thing to help society and help people get well. And I think that bodes well in terms of the answer to your question.

I think our American people want to be part of a good health delivery system. And if they're part of the actors, I think the chance of our kind of approach working fiscally and stabilizing things will do a lot to putting people in the right niche as they choose to serve their fellow Americans with health care.

MR. HASKINS: Please join me in thanking the members of the panel. And stay in your seats. We're going to get the next panel up here very quickly. (Applause)

MS. SAWHILL: I'm Belle Sawhill, and along with Ron Haskins, I've been very interested in these fiscal issues for quite a long time. And we have been meeting with a group of budget experts that we call the Fiscal Seminar, co-sponsored by Brookings at Heritage, for a number of years. And we have just produced this paper on premium support.

Two of the authors of that paper are here on the panel. One is in favor of premium support, and that's Jim Capretta, and the other is not in favor,

and that's Henry Aaron. And they, along with four others, are going to discuss the pros and the cons of premium support.

The Fiscal Seminar paper, by the way, does include a nice description of the Domenici-Rivlin plan, so that is the version of premium support that we are discussing here. I think one point we all would want to make or emphasize is that premium support can be many different things.

The devil is often in the details, and so it's good to have a specific proposal to discuss, and I find it very interesting that Ryan-Wyden is so similar to Rivlin and Domenici, and so you can consider this as a discussion of both if you like, to some extent. I mean there may be some details we don't quite understand yet.

Now, in addition to Jim Capretta and Henry Aaron, we have Judy Feder from the Georgetown Public Policy Institute, we have Paul Van de Water from the Center for Budget and Policy Priorities, we have Stuart Butler from Heritage, and we have Doug Holtz-Eakin from the American Action Forum.

I am not going to talk about their bios, you can read them. I think if you do, you will be impressed with the extent of expertise on health care policy that we have assembled here this morning. I'm a little bit intimidated myself. But with that, let me start with Judy Feder to make some brief comments on premium support.

MS. FEDER: Thank you, Belle. And no reason to be intimidated, you always hold your own, no problem there. It's good to be with you all this morning. I want to start with what Senator Domenici said in talking about the proposal. As a supporter for premium support, he recognizes that he and other supporters are asking us to replace a longstanding public insurance program through Medicare with vouchers for private insurance and Medicare, something,

as he emphasized, that is really new and untried.

And you'd think, given that he and others are asking for such a change, that an argument would be based on evidence, that private insurers and competition among them had successfully guaranteed equitable access to affordable care while, on the other hand, that Medicare program has just done a lousy job. Funny, the evidence shows us exactly the opposite. Now, I'm not saying that Medicare is perfect, its record is far from what it could be, but it's payment mechanisms, like those for all of health care, need reform.

But relative to private insurance, which is the alternative being proposed, Medicare's performance is extraordinarily impressive. First, and perhaps foremost, Medicare does a terrific job at what any successful insurance plan has to do. It pulls risk without regard to health status, bringing together lots of people when they're healthy to pay for care when any of us or any of them, although it will soon be us, become sick. It's a large risk pool.

Competing private insurers, in contrast, profit just like their shareholders want them to do, by focusing on and serving the healthy and avoiding the sick. With competition among private insurance plans, it takes aggressive government intervention and oversight to assure that doesn't happen, and that's what the exchange is supposed to do, that's what Diane Meredith was talking about when she went, and she and Alice talked about risk adjustment, it's making sure that there's not discrimination against us when we're sick and preference for the healthy.

The whole market works against that, and as I said, it requires very aggressive oversight, the kind of aggressive regulation that Senator Domenici minimized that's necessary to make this work. So it's a real issue of

government enforcement, it's not something you can lightly pass over, and I think Paul Van de Water is going to say more about how challenging that task is in a minute.

But to get back to my comparison, in Medicare, because it is one single risk pool, for the most part, except for the private plans in Medicare now, one single risk pool, that risk pooling just comes naturally, don't need a lot of management to make it happen.

Now, having tens of millions of people in a single pool also gives Medicare an edge in dealing with providers who are increasingly concentrated, and therefore, increasingly effective in driving up payments where they can.

Medicare pays hospitals about 30 percent less than private insurers do and pays physicians about 20 percent less. In overwhelming numbers, however, providers accept what Medicare pays. Why? Because they can't live without Medicare's business. But that's not true for private insurers who increasingly confront providers with close to monopoly power, whether because insurers who don't have a lot of market share lack the clout or, in some cases, because they lack the market pressure, private insurers have been markedly ineffective in resisting private pressure to increase premium payments.

If your goal is cost containment or value for the dollar, which it clearly is, why do you give up Medicare's considerable purchasing advantage, divvy it up among multiple players? Beats the hell out of me.

Now, Medicare's greater success and controlling costs is not just in the level of spending, but also in rates of growth. Historically, Medicare per capita spending has grown a bit slower than the private sector. But when Medicare is serious about containing costs, as is demonstrated by the Affordable

Care Act, the difference really shows.

CBO finds that Medicare premiums, currently estimated to be 11 percent below the private insurance premiums, for the same benefit package will be about 30 percent lower by the end of the decade.

Now, let me take the end of the next decade. Let me take this growth rate apart a little bit so we can understand what's going on. It's important to remember that Medicare cost growth reflects two components: growth and cost per capita and growth in the number of capitas or enrollees. Looking out over the next 10 years, the combination of the two, per capita cost times cost per capita -- excuse me, per capita cost times number of capitas, leads to an overall aggregate growth rate of 6.7 percent. And it was the aggregate growth rate that was on the chart that you all were talking about.

That's the number that critics of Medicare focus on in raising concern, and it is of concern. But it's actually the growth in the capitas that has come to drive cost faster than GDP, and that's because, not surprisingly, we baby boomers are joining the program and will continue to do so at a rate of about a million and a half a year.

When it comes to health care costs per person, Medicare's growth rate is remarkably low. As a result of the payment changes in the Affordable Care Act, Medicare per capita spending is projected to grow at an average rate of about 3 percent a year, as much as a point below the growth in GDP per capita, and even lower or at about the same as growth in GDP per capita if we fix the position payment formula, the SGR.

So my thought is, I really don't know why we don't declare a victory and just keep at it. Taking $500 billion out of the Medicare program, as

we did in the Affordable Care Act, without endangering access, makes a pretty big dent.

Now, not only is the growth rate that we are now projected to achieve below the Rivlin-Domenici target of GDP + 1, it's also enforceable, which Alice talked about. The Affordable Care Act does set up a mechanism to enforce growth rate. If Medicare spending growth exceeds GDP + 1 per beneficiary, the Affordable Care Act Independent Payment Advisory Board is charged with proposing changes to lower the growth rate, which are then fast-tracked through the Congress. But the fact is that the cost reductions the ACA has already put in place slowed spending so much that CBO finds is unlikely that this board will even be activated in the coming decade.

Why then is this argument to shift from a strong public insurer to vouchers for private insurance on the table? Well, I think there are a lot of reasons, not the least of which is ideology. And despite the fact that its staunchest advocates are now walking away, like we heard Congressman Ryan yesterday, from cost, saving money being the primary goal, I suspect it's because we'd like more cost containment than we already have, which you pretty much said.

Vouchers that take apart the strongest means we've got for that mechanism are not the way. It's not that we should abandon or weaken public insurance that is demonstrably superior to the alternative that's being proposed, undermining Medicare's risk pooling and its market power, its equity and efficiency in one fall swoop. It's to make that public health insurance work better and to extend the improvements in payment and delivery reform that its market power make possible to the whole health care system. That's what the changes

in the Affordable Care Act were all about and that's the path that will allow efficiency, equity and affordable health care in the future. Thanks.

MS. SAWHILL: Thank you, Judy, and thank you for staying within your time limit.

MS. FEDER: Close.

MS. SAWHILL: Close. So next up is Jim Capretta. I neglected to say where you were from earlier, Jim, I said you were an author, and Jim is a fellow with the Ethics and Public Policy Center and a member of the Fiscal Seminar.

MR. CAPRETTA: Thank you, Belle. I'm pleased to be here this morning. I think you might not be surprised to see that I might be on a parallel universe with Judy. I read an interview with the just recently departed CMS administrator where he made the statement just the other day that, you know, the problem in our health care system is the health care delivery system. It's not with Medicare is essentially what he said, or Medicaid. And I'm here to argue I think that he's got basically it wrong. Right? The proposition I think he's actually really wrong about, which is, is the health care delivery system problem totally unrelated to the way Medicare is currently structured? And I think the evidence shows that it absolutely is related to the way Medicare is currently structured.

Medicare, as Judy indicated, is the dominant payer in most marketplaces. We have a problem in American health care that is essentially related to, has been analyzed every which way, fragmentation, inefficiency, lack of coordination, too often very poor care, duplicative tests and procedures, over use of procedures and so on. What is the primary driving force behind that? It's Medicare fee-for-service. Ninety percent of the participants in the Medicare fee-

for-service program have supplemental insurance, which means that at the point of service, they actually pay nothing.

Yes, Medicare has quite a bit of cost-sharing associated with it, but for the vast majority of participants in the program at the actual point of service, there is no cost to the beneficiary. So there's a tremendous volume incentive in the Medicare fee for service world that is driving very substantially the inefficiency that exists in health care delivery. So to argue that the health care delivery system is totally unrelated to Medicare I think is just plain wrong.

The second point I want to make is we have a key question we need to ask, which is, which process will bring about higher quality and higher productivity in that delivery system? That's the question we're trying to address. How are we going to bring that about? Because if you don't bring about higher productivity and higher quality, any effort you do, including many of the things that Judy referred to, across the board cost-cutting and Medicare, actually result in erosion in quality, not an improvement in quality. And the only way to make the system less expensive without eroding quality is to make it more productive, and how can you do that?

Now, one answer, the one I think Judy is trying to promote, and Dr. Butler tried to promote in this article, was that actually the government can make that happen somehow through accountable care organizations, bundled payments, the innovation center ideas that are coming forward. I'm here to tell you that I think that's going to fail.

The government -- this is not a new idea. The government has been trying to push through the Medicare program to get to a higher value, lower cost delivery structure, through the Medicare program, for 30 years. It's not a

new idea, and it hasn't gone very well.

Now, why hasn't it gone very well? A good example might be what they tried in the 1990s called the Centers of Excellence Demonstration, where the HCFA -- then HCFA -- was going to go out and figure out which hospitals were centers of excellence, designate them as such, and then, you know, put their toe in the water and start steering the beneficiaries in the Medicare program to those hospitals as opposed to the other non-centers of excellence.

The first announcement went out designating the hospitals. All of the ones who weren't on the list said, hey, what's up? You know, how come we're not a center of excellence? They said the data was lousy. They went to the Hill and they killed the idea. This has been repeated over and over and over again in the Medicare program. It's what I would call the Lake Wobegone effect, okay. Basically every provider in the Medicare program is slightly above average and they always pay everybody basically the same. They have an incapacity to put low value providers out of the program. To get delivery system reform, to get higher productivity and higher value, you've got to get the low value people out, and Medicare just can't do that.

Now, the question is, can a competitive private delivery structure driven by premium support bring about a better outcome? I think the answer and the evidence is pointing in the direction of yes. Do we have a randomized trial that we can experiment, you know, have a study that we can run for ten years and figure this out? No. You're going to have to look at the evidence that's available and make some judgments.

The first piece of evidence, of course, is we have a Part D

program that is essentially premium support for drugs. What's happened in the Part D program? The premium in 2012 is going to be $30 on average across the plans for the beneficiary.

In 2006, this is after 6 years of experience, in 2006 it was $26, okay. There was an amendment offered when the thing was being considered, trying to make sure that the beneficiary paid no less and no more than $35. If that amendment had passed, they'd probably be paying more, okay. The program has actually worked pretty well; lots of predictions that it would never work, that private insurers would never participate, it would be too confusing, nobody could move from high premium plans to low premium plans. All that has been proven wrong. There has been migration from high premium to low premium plans. That's why the premiums have held relatively steadily.

Some people have argued, well, this is a national trend, it's happened throughout the whole health -- prescription drug program. It's true that nation-wide drugs have come down, but they haven't come down as much as they have in Part D. On average across the country it's been about 27 percent. In Part D, it's been about 40 percent compared to the 2004 projections.

Generic substitutions have moved up faster for the elderly than it has for the non-elderly. So there's been effect of the Part D program, competition, moving people into lower cost options, and it's worked. People actually want to pay lower premiums, and if you give them an option that's reasonable, they'll sign up for it.

I was told the other night, I can't verify this, I haven't had a chance to verify it, but Stanford University has essentially a premium support program for their current employees. They now have 70 percent. Apparently people in

Kaiser Permanente, which is the low-cost option in Northern California, that's delivery system reform. If you're going to have changes on the ground in how medical care is actually delivered to patients, you're going to have to have more people signing up for organized integrated systems that are the low-cost option. Kaiser does it quite well, they've run it in California for a long time. And on the ground, when you give people the choice and you make them pay the premium, the evidence is showing they actually sign up for it, more than they would have otherwise.

Now, there's going to be some judgment involved in this. Do we believe that the government can manufacturer a higher value, more efficient health care delivery system or do we think some level of competition and incentives will bring it about? That's fundamentally the question.

And I think the evidence is overwhelming that the government has been trying unsuccessfully to do it and now people are saying, well, give it one more try for the next decade. We've got this demo, we've got this innovation center. It's very, very likely to end up, as all the others have, with the Lake Wobegone effect, with all the doctors still in the network, all the hospitals still in the network, and all of them essentially paid the same.

You can't bring about delivery system reform by doing that. So we need to move to a system where consumers make more choices, they can drive efficiency in the system, and the low-value people actually get kicked out through the private sector. I think I'll stop there. Thank you.

MS. SAWHILL: Thank you, Jim. Paul Van de Water.

MR. VAN DE WATER: Thanks, Belle. If premium support is to

have any chance of working, health insurers must be pressed to compete on the basis of providing value for money rather than attracting health enrollees and deterring sicker ones.

The Rivlin-Domenici plan makes a number of steps in that direction but still falls short in critical areas. First is low-income protection. The proposal says that current Medicare beneficiaries with low-incomes will be guaranteed access to traditional Medicare with no additional premiums. That's fine as far as it goes, but it doesn't apply to new beneficiaries and it doesn't apply to anyone whose income is greater than 135 percent of the Federal poverty threshold. Thus, elderly or disabled individuals with incomes as low as $15,000 our couples with incomes as low as $20,000 could face higher premiums.

Second is the scope of benefits. Today, Medicare advantage plans can reduce the scope of some benefits if they increase others or reduce certain cost sharing, as long as they provide the same actuary value as traditional Medicare.

The Ryan-Wyden proposal explicitly adopts an even weaker actuarial value standard, and from what Alice said earlier the Rivlin-Domenici plan appears to do so as well. And even if a plan nominally covered the same services as traditional Medicare, it could still fall short in terms of the adequacy of its network, waiting times, customer service, or other features.

Now, although it might be possible in theory to add elements to a premium support plan to make it seem acceptable on paper. These additional elements are, as a practical matter, impossible to enact or implement in the current political climate.

Proponents of premium support acknowledge that risk adjustment

is critical to its success, but there is good evidence that current risk adjustment technology is inadequate to the task. And moreover, insurance companies are trying to withhold data necessary to assure that risk adjustment under the Affordable Care Act is allowed to meet its potential.

Further, any premium support system should discourage risk selection by standardizing insurance offerings. The Affordable Care Act requires that plans offer to the health exchanges, provide an essential health benefits package, and empowers the Federal government to define its components. But here, too, insurers are trying to undercut the law by proposing that the essential health benefits package be defined in terms of a dollar value, rather than a specific set of coverage services. In this way, both he Rivlin-Domenici and Wyden-Ryan proposals would allow insurers to continue to engage in cream-skimming through plan design.

To compete with private plans on a comparable basis, traditional Medicare would need authority to offer an integrated benefit package, including drug and supplemental coverage, to update that package in response to changes in the healthcare system and insurance markets, and possibly to offer various benefit options, such as preferred provider organizations. Congress is unlikely to provide that authority in light of the opposition which we saw to include a strong public option in health reform.

Even if a premium support plan included the necessary consumer protections, monitoring and enforcement of those protections would be difficult. State insurance regulators complain that the federal government does not now adequately protect consumers from deceptive practices by private Medicare plans. They've sought authority to enforce state laws and marketing practices,

but insurers have succeeded in blocking this proposal and will likely continue to do so.

Traditional Medicare is a popular program for the reasons that Judy Feder has explained. The program has a strong record of innovation and cost control. Before substantially restructuring it, we need to be confident that the new arrangements will be allowed to work even better. This is particularly important since Medicare beneficiaries face many more challenges than those of working age in dealing with a competitive choice-based system. Many have physical or cognitive impairments that make it difficult or impossible for them to assess alternative packages or to cope with limited provider networks or other restrictions.

For this group, a poorly-implemented premium support plan would impose particularly high costs. Only when the Affordable Care Act exchanges have been up and running effectively should we consider introducing a similar arrangement in Medicare.

Judy Feder, Henry Aaron, and I share the concern that Senator Domenici and Alice Rivlin have with constraining cost growth in Medicare. But we have a different vision of how best to achieve that goal. The Affordable Care Act takes important steps to slow the growth of healthcare costs, as Judy has said, through host delivery system reforms. And as a backstop, it creates an independent payment advisory board that will make sure that spending growth beneficiary is limited to the growth of GDP per capita, plus 1 percentage point, the very same growth rate target promised by the Rivlin-Domenici and Wyden-Ryan plans. And unlike premium support, it does so without reducing benefits or potentially shifting cost to beneficiaries. We shouldn't abandon that approach

before giving it every chance to work.

Now, in my last couple of minutes I'd just like to say a few words about the points that Jim Capretta has made with regard to delivery system reform. First, we have to remember that despite the acknowledged political impediments which Jim has cited, nevertheless citing Judy's figures Medicare has still had a better cost control record than the private sector. So, that's important to keep in mind.

Secondly, with the Affordable Care Act we do have an important new institution, the Independent Payment Advisory Board, which is an effort to try to get around some of the political roadblocks which have heretofore been in the way of Medicare being able to do an even better job.

And the Congressional Budget Office said last year, CBO's director Elmendorf, that the Independent Payment Advisory Board, along with the tax on high-cost health insurance plans in the ACA, represent two of the most important new cost control mechanisms that the ACA puts in place.

As far as the innovative record of private plans is concerned, that leaves a lot to be desired. You know, people have promoted -- I think Senator Domenici mentioned the record of the Federal Employee Health Benefits Plan. But as a Federal retiree and a participant in one of the largest plans within FEHB, I can speak from experience that despite significant amounts of cost sharing, or skin in the game as proponents of premium support like to call it, the plan still does remarkably little to hold down the growth of cost and precious little in the way of care coordination.

So, I think that to reiterate what Judy said, if one looks at the record, Medicare heretofore has done very well compared to private plans. And

we should be very cautious before we risk traditional Medicare for a new, untried scheme.

MS. SAWHILL: Thank you, Paul. And next will be Stuart Butler.

MR. BUTLER: Thank you very much. As Ron Haskins kind of explained in his introduction to the publication that you have, the idea of premium support has a very, very long history and a bipartisan history. Henry Aaron, of course, with Robert Reischauer coined the term, and back in the 1990s there was considerable discussion of it. We had a bipartisan commission centered on that idea. More recently, of course, we've had other proposals such as the Domenici-Rivlin plan, and now more recently this plan. The Heritage Foundation for many years has supported that and you have a publication along those lines. So, it's something that has been developing and being refined constantly over many, many years.

And I think when you look at it, you see the themes becoming clearer, and I think the range of debate and the engineering aspects are getting clearer and sort of narrower in the sense of being a greater consensus. That said, I think the concerns that are raised and are raised in Henry's paper, for example -- and have been raised generally over that whole period -- have a validity to them. They are concerns that have to be constantly addressed, and I think we are engaged in what I would call an engineering discussion about precisely how to do that and how to improve them. So, I see this as very much an iterative process of a basic design and a basic idea.

When you look at the themes of premium support, I think some -- there are a number of them that are very clear and evident, and I think then lead to further discussions about how best to structure them. One which is not unique

to this is the idea of a long-term budget for Medicare. Some longer-term cap or determined amount that should be spent on the Medicare program that are critical, today, because of our budget situation. I think it's also critical in terms of seeing Medicare alongside other national goals that have to be discussed and debated, and that money is debated accordingly and distributed accordingly. I think that's one of the key features of premium support, but as I said is not unique to premium support.

The second theme, which flows from the first, is that the device used to maintain a reasonable budget over time on the premium support is to provide an adequate level of support, of finance, to individuals to be able to obtain an adequate level of services. Now, we can debate exactly how that should be, but that's a basic theme. As opposed to methods, say, in the United Kingdom, where I come from originally, or Canada that says, let's give certain amounts of money to providers or to institutions or to regional health authorities and let them distribute it. So, there's a strong theme of putting control and choice into the hands of individuals, as opposed to going through area authorities or something like that.

A third element which is critically important is that thinking about where to set this amount of support as a baseline or benchmark, I think increasingly people who share the view of premium support recognize that it's got to be connected to actual costs of healthcare. And in the Domenici-Rivlin plan and others and the Heritage Plan, we look at some kind of competitive bidding process to say the amount of money you get really does have to be tied to actual cost. Now, should it be the lowest cost plan or the second-lowest, as in Domenici-Rivlin, or some market basket of below-average, below-median plans?

That's up for conversation and debate, and you see that in the different plans. But linking it in that way is very important for the benchmark.

Then as you think about over time, you have the issue of how rapidly do you allow any budget to grow? And that's another central theme and central discussion. What should the indexing be of any kind of plan? It seems to me when you look at what is the objective of indexing the rate of growth, you're really trying to balance three goals or considerations. You're trying to reach a budget objective, which in these days with our concern about debt and the economy is a really important objective. You're trying to do that, but at the same time you're trying to bring about a reasonable balance of financial risk between beneficiaries, between taxpayers today, between them and beneficiaries and taxpayers in the future, the debt, and so forth. You're trying to juggle these different goals for the index simultaneously.

And within the beneficiary financial risk, you're also looking at low-income and high-income people. And that's why you see income adjustments built in to good premium support systems in terms of making sure that the people at the low end are as insulated as best you can from financial risk, but maybe people -- Warren Buffett, maybe -- should shoulder a little bit more risk that somebody else. So I think that's a very, very important theme.

And I do agree very strongly with Henry and others that when you look at an indexing system, you've got to relate it in some way to the cost of healthcare. That's why I favor looking at actually an inflation, CPI plus 1-based system as opposed to a growth in the economy system. But this can be debated. Both are intended to try to get the right balance within these goals.

I think -- so, the indexing is really important. Fifth, I think it's very

important -- and you see this again in this debate about when does something like this click in? I don't think we should exempt baby boomers from having to shoulder some of the risk and some of the cost about meeting these goals. I think because, you know, Bill Gates happens to be, I think, 57 years old, I don't think he should be removed from having to have some skin in the game in terms of carrying the financial risk as a baby boomer. So that's why I and others, I think, who support some features of premium support argue for it coming in much more quickly for those individuals. Politically, that's difficult, no question about it, but I think in terms of what is a right and fair way of doing it makes a lot more sense.

The sixth theme I think which is important, which you're seeing increasingly discussed in premium support, is that yes there does have to be an infrastructure of information, of appropriate consumer protection, and exactly how you do it can be debated. We can build on existing structures in the Medicare program. We can create an exchange system, as Rivlin-Domenici does. Some version of this has to be in the system. I don't disagree with that at all, and I think that's an essential element of thoughtful premium support systems.

And then I think also -- and this is sort of just a return to a point that's been made a lot of times. I think that in terms of thinking about fee-for-service. fee-for-service in my view and I think the view of most people who support premium support should neither be artificially protected nor should it be artificially closed down. What we should do is look at the fee-for-service system and structure it so that it can be seen as essentially an open network system with a premium associated with that, and that that premium is subjected so to speak to the premium support system itself. So it's not that you say we've got to phase

out fee-for-service, we say it's got to be structured with a premium and with appropriate risk adjustment so that it actually does compete.

Judy Feder is correct. If it really is the most efficient method of dealing with healthcare that god has ever imagined, then ultimately it will prevail in that competition, but it's got to be on an even basis.

So, I think in conclusion when you look at premium support, as I said it's got a long history. I think its themes are clear, its objectives are clear, but it's recognized that it's a constant iterative process of refinement and engineering to deal with a very legitimate issues that come up. This is not unique to this particular way of dealing with the problem. It's got to be refined and so on.

And I think the most recent iteration, the Wyden-Ryan bill, is an excellent example of another stage in this process. I think it deals with a lot of the issues that were raised, it doesn't deal with them all, but I think it is another step forward in the way that we have to go to deal with the budget problem and also getting an affordable, acceptable level of healthcare for seniors and one that's also affordable for future taxpayers and future seniors and our children and grandchildren.

Thank you.

MS. SAWHILL: If your noticing a pattern here that first we had one person who is in favor of -- or, is against premium support and then someone who is in favor of it, you're on your toes this morning. And so, in the last set of pairs here, pro and con, I'm going to call on Henry Aaron, my colleague here at Brookings who is another author of one of these papers that we're releasing today. And then finally, to Dough Holtz-Eakin. But, Henry first.

MR. AARON: I thank you very much. My text for today is a

remark attributed to John Maynard Keynes. When the facts change, I change my mind. What do you do, sir?

In 1995, when Bob Reischauer and I coined the term "premium support" and described its characteristics, the environ then for health policy was rather different from what it is today. The Clinton health plan had failed, hope for systemic health care reform was dead, Medicare spending per person was rising faster than other healthcare spending, and several groups had endorsed or come close to endorsing replacing Medicare with vouchers that people could use to buy private insurance. We thought that simply dropping money on the Medicare population and asking them to fend for themselves in the famously dysfunctional small group insurance market was a recipe for disaster.

So, we put forward three conditions for such a shift. The vouchers should be linked to an index that grows as fast as overall per-person healthcare spending. Insurance offerings and selling arrangements should be aggressively regulated, and risk adjustment had to be good enough to make cream-skimming by insurance companies unprofitable.

The linkage to health cost index was critical. Savings had to come from genuine efficiencies, not from offloading costs onto the elderly and disabled. Aggressive regulation was essential, because insurers have the bad habit of overloading customers with so many plan variations that nobody can possibly choose rationally among them. Furthermore, plan offerings and sales methods can subtly or not so subtly abet competition based on risk selection. For example, we offer sports medicine benefits. Hear about our plan after the dance. It starts at 8, ends at 11, the venue is on the 2nd floor, sorry, no elevator. (Laughter) And risk adjustment had to be good enough so that insurers could

make money only by competing on what counts: Better service and higher quality of care.

Well, 16 years have gone by since Bob and I wrote, and some things have changed, some others haven't. The most important change is basic healthcare policy. But we've also gained a deeper understanding of what we don't know how to do, and we've learned the limits of what elected officials are willing to do.

On policy. First, Medicare has changed. Most notably for purposes of today's discussion, the sort of competitive system that voucher advocates say they want to create already exists. The average Medicare enrollee today may choose among an average of 24 plans in addition to traditional Medicare, including an average of 10 health maintenance organizations. Furthermore, Medicare spending per person is slated at least for the next decade, and under current law, to rise less than the targets set under the Domenici-Rivlin and Wyden-Ryan plans.

Second and most important, systemic healthcare reform is no longer a pipe dream, it is the law of the land. The Affordable Care Act sets in motion a process of experimentation and change long overdue, but with the potential to revolutionize how the United States pays for and delivers healthcare. Not every element of that plan is going to succeed, but some are likely to do so.

We're going to try ACOs, accountable care organizations, bundled payments, comparative effectiveness research, a center for innovation, just to name a few. An independent payment advisory board. It is also going to lower reimbursement directly by curbing Medicare spending by roughly half a trillion dollars of the next decade.

MR. AARON: To be sure, implementation of the Affordable Care Act is going to be hard. States are now discovering that the prospect of enrolling 29 million people in health insurance exchanges and avoiding competition based on risk selection won't be easy. They're working on those problems and I think they can solve them.

But dealing with nearly 50 million Medicare enrollees would be vastly harder. Why? Because per person spending under Medicare is three times that on those who will be served under the Affordable Care Act, and the variation on spending is correspondingly larger, so, therefore, is the profit from cream skimming.

Furthermore, as noted, many Medicare beneficiaries are people with mental disabilities and early or advanced mental decline. The recently announced Wyden-Ryan plan promises to provide voucher recipients with, "clear and easy to understand information" on various plans.

Now, those of you who are old enough, I ask you, have any of you actually read the clear and easy to understand information that Medicare and private insurers now distribute to enrollees? If you have, then I think you'll agree that to think that providing such clear and easy to understand information equips those with mental disabilities or even early state dementia, the capacity to deal with competing insurance plans, is simply delusional.

So, what is the take away? Well, first, contrary to the allegations of critics, Medicare works. It provides benefits fairly and at lower overall cost than typical private insurance plans do.

Second, the so-called premium support plans put forward so far are not very well designed. They lack the regulatory teeth necessary to make

premium support even worth considering.

I've lost my page here.

MR. BUTLER: You can take one of mine.

(Laughter)

MR. AARON: I haven't sunk that low. Third, even well designed premium support plans are not -- I've said that -- are not ready for prime time. We have work to do in implementing the Affordable Care Act. When that work is done, then we will be able to decide whether it makes sense to extend similar arrangements to Medicare recipients.

And, fourth, there are important changes to be made in Medicare that will improve its operation. Among those changes would be to give the Centers for Medicare and Medicaid Services the administrative resources they need to reduce improper payments and to enforce coverage guidelines, reform of supplementary insurance is long overdue, and the Congressional Budget Office Options Book contains a long list of modifications to Medicare, many of which were endorsed by the Rivlin-Domenici plan that also should be enacted.

Finally, controlling overall healthcare costs is genuinely, as Alice said, urgently important. The need to lick that problem is why the nation's top health priority now is to implement the Affordable Care Act, not to replace Medicare, a well functioning and popular program, with an untried alternative distressingly similar to private plans that so far do a poor job of serving the elderly and disabled than Medicare does.

I have to add just one point. Stuart wants Bill Gates to have more skin in the game. I don't know how much Bill Gates makes. Let's assume he makes just $5 million a year. If he does so, he is paying $145,000 a year in

payroll taxes for Medicare Part A, and when he reaches age 65 he will pay a premium equal to 80 percent of the value of Medicare Part B. How much skin in the game do you really want, Stuart?

MR. BUTLER: One hundred percent.

MR. AARON: He's got more than 100 percent already.

MS. SAWHILL: Thank you, Henry. Last, but not least, Doug Holtz-Eakin.

MR. HOLTZ-EAKIN: Thank you, Belle. Thank you for your patience.

It's not easy going last, so let me be brief. Jim and Stuart are right. Judy, Paul, and Henry are like my children, loveable but misguided.

(Laughter)

No, I think it's important to recognize that it is a welcome thing for us to have a return to a tradition of bipartisanship, which is about reforming Medicare to be sustainable for the future and to be the safety net program we need, and a departure from the more recent bipartisan tradition of attacking anyone who proposes to change the status quo in Medicare, because that tradition leads us down a very dangerous path.

The status quo in Medicare is simply unsustainable, dangerous to beneficiaries, dangerous to the federal budget, and dangerous to the economy.

You know, we know that, at the moment, the gap between Medicare premiums and payroll taxes paid in and spending going out is $280 billion. Ten thousand new seniors are going to retire everyday, and that program simply is unsustainable. It is a disservice to attack anyone who recognizes that this crucial piece of the safety net has to be made solvent over the long run, and

that's been the tradition on both sides in recent years. We simply have to get away from that.

I applaud Alice and Senator Domenici for leading this charge. I'm delighted to see Congressman Ryan and Senator Wyden stand up and talk about these reasonable changes for the future yesterday, and I was disappointed to see the White House immediately dismiss it. This is something we simply cannot, in good conscience, tolerate as a public. We have to make some changes for the future.

Now, what would this do? I want to echo some of the comments that have been made before me. Part of the problem with the status quo is that it embodies a fundamental contradiction. It says to American beneficiaries, you may have all the finest medical science America can invent at low or no cost, and that turns out to be very expensive, $280 billion cost overrun right now.

And so the Congress has to try say stop that. And they either literally say stop that by cutting something off, or they cut reimbursements to the point where providers stop seeing Medicare beneficiaries. That's not a solution. We've seen that in Medicaid, a program that does not serve its population well at all. Moreover, the beneficiaries recognized this right away and they revolt. They say, wait, that wasn't the promise. You said I could have all I wanted.

Until we actually break that contradiction, until we say to the beneficiary and the provider community, "these are the monies that you have, here's the budget, go provide a sensible set of services in an efficient way," we will never solve that problem and the program will break under its own weight.

So, I'm with Stuart. I think one of the most important things that must be done is to put a budget on Medicare and a premium support program is

a way to put that budget in place.

Now, there are others, and you'll notice that in Domenici-Rivlin and in Wyden-Ryan, there's also an overall backstop, which puts the budget constraint in at an aggregate level, and those two competing visions of how to put the budget on, I think, are ones that we have to play out, and the competition is an important one.

I personally favor the one that puts the money in the hands of the beneficiary, because we have seen so many times in America this debate over who gets to make tough health decisions, and what the American public has decided is, it's not going to be an insurance company and it's sure not going to be a government bureaucrat, and so in the end it's going to have to be the American family that makes those tough care decisions and you ought to put the money in the place where the decisions are being made.

And, so, I'd like to see a budget constraint, premium support provides that, it also aligns the incentives with the ethical norms that Americans believe, and I think that's something that we will inevitably end up and we ought to just simply move the program that way from the beginning.

Second thing about the status quo that is, I think, quite clear is that it drives bad medicine. I want to echo what Jim Capretta said, look at the Medicare program. It's got these payment silos, Part A for hospitals, Part B for doctors, Part C for some insurance companies, Part D for the drug companies. There isn't a beneficiary to be found in there anywhere. It's a fragmented, uncoordinated system that drives bad medicine in America and we can't afford bad medicine, it's too expensive.

We need to have a delivery system reform that gets us toward

more coordinated care and ones that anticipate the kinds of diseases that you have late in life with preventive care earlier on. This is a route to that and I think it's very, very, very important that we pursue it.

I also want to just, you know, take the liberty of just pointing out that all of the concerns about the risk associated with this are exactly the concerns that I heard as director of the CBO when the Medicare Part D program was enacted in 2003.

That program is very much like the premium support programs that we are talking about today. They had the came concerns about too many choices at one extreme, at the other extreme, private plans would never enter and provide this. Neither of those concerns turned out to be true.

Had the same concerns about how do you do reinsurance and avoid adverse selections. None of that turned out to be a problem. Had concerns about the costs of the program. It has come in under cost. The competitive program in Part D is the single best entitlement program we have.

We should be modeling all our entitlement programs on successes, not on something else, and the Part D program is the shining success in our entitlement programs, and I think we ought to move more toward that at every opportunity, and this is a chance to do that.

So, I think the last think I'll say, and then we can just close and get to the audience, is that something that has not been discussed yet and a feature that I find interesting in what Wyden and Ryan rolled out yesterday, is the notion that you could allow employees in small firms to opt into this premium support program before the official Medicare eligibility age.

I think that's an essential piece of the policy development that we

have to address. There's been a lot of talk about portability in the insurance, from job to job, job to home, it's an important discussion. But the most missing portability right now is from early retirement age, 62, to Medicare eligibility, and they have taken a small step toward actually filling that need.

It also aligns the incentives much better. If you, as an insurer, know that you have this person, perhaps a 45 year old, and you may have them until they're 85, your decisions about what is an appropriate set of things to cover in terms of prevention and early interventions, is completely different than the annual model on which most of insurance is modeled.

So, I think these are all very sensible designs. It's important to have this program survive to the next generation and this is a way to do it in a rational, ethically sound, and efficient fashion.

MS. SAWHILL: Thank you. I have lots of questions myself, but I think I want to get the audience in now because we are running out of time. So, I'll take a couple of questions from the audience.

Please introduce yourself and make your question brief. Let's start right here.

MR. RAVEN: Medicare is a major problem in terms of costs.

MS. SAWHILL: Introduce yourself. David Raven, Georgetown University. However, the healthcare cost issue is a national problem, not just a Medicare problem. We've heard, historically, Medicare costs less per capita than private insurance, it has the market power to change the healthcare system, we've also heard, with agreement, the healthcare system should be changed.

I can't quite understand why we don't take relative certainty, a program that currently is more effective in containing costs, and accept instead

an increased risk of having more people under private insurance. It seems to me that if we're concerned about the government problem, concerned about the national problem, we should be talking about a Medicare -- improved Medicare, a more cost contained Medicare, for the entire population, and I wonder why that wouldn't be your recommendations?

MS. SAWHILL: Thank you. Rather than everybody trying to respond, because we really are short on time, let's just take a couple more questions, get them all on the table here, and then we'll give a couple of you a shot at answering them.

Yes, back there in the red sweater?

DR. POPLIN: Hi. I'm Dr. Caroline Poplin, a primary care physician. My question is for Mr. Holtz-Eakin. You're assuming that consumers -- every consumer will be faced with the same choice and -- but in fact, 20 percent of the Medicare population is responsible for something like 80 percent of the cost.

Disease is chronic now. So, a healthy person can pick a high deductable, high co-pay plan and that will be fine. A person with chronic illness, that plan won't work at all. They're going to have to choose a different kind of plan that has -- because they're going to have to pay all the co-pays and deductibles. What do you do about the fact that patients will separate themselves out into people who are sick and people who are healthy?

MS. SAWHILL: Okay, not seeing anymore strong hands -- I saw somebody tentatively trying to get in over here. Okay, one more. Yes, you.

MR. GOLDBERG: Hi. Lee Goldberg with the National Academy of Social Insurance. It seems like there's sort of two discussions going on here,

one is a disparagement of fee for service and the lack of coordination and fragmentation in the healthcare system, which, admittedly, is a problem.

And then a question about private plans versus a public program, and in the current program, current public Medicare program, you can be in a private HMO or you can be in a fee-for-service. If you are, presumably, in a premium support system, you still have the same set of choices and there's no guaranty that people are going to be in a more integrated, coordinated plan.

So, it seems like there ought to be a more honest discussion of, in fact, what people want to do here is force people into more coordinated plans, and maybe that's a good thing, but that's sort of a different national discussion.

MS. SAWHILL: Interesting comment. I don't think -- well, if you're very short, you may have one last comment here in response to these questions or anything else you've heard. Starting with Judy, and we'll just go down the line quickly, but please, 30 seconds.

MS. FEDER: All right, David, I clearly agree with you, Carolyn, I agree with you, too, and Lee, I agree with you too. But to pick up on Lee's question --

MS. SAWHILL: My god, she packed the audience.

MS. FEDER: No, that's you -- you picked them. But Lee raises what I think is a very important question. There's been, I think, a discussion in terms of advocacy of premium support as a correction for fee-for-service that acts as if the Affordable Care Act never happened and doesn't accept the change in the facts that Henry alluded to.

The fact is, that everybody agrees we need to change the delivery system and to make it more coordinated and more integrated. Private insurers

don't do that. Medicare, which actually Jim acknowledges has market power, is now charged with moving in that direction. And that's the direction, using Medicare in connection and leading the whole healthcare system to improve it that we ought to go.

MS. SAWHILL: Final comment, Jim?

MR. CAPRETTA: Well, there's so much to say about some of these questions, but, first of all, on the issue of whether Medicare is a better performer on cost than private plans, actually, if you look at the MedPAC data and look at the HMOs that are participating in Medicare Advantage, they actually deliver the same Medicare package of benefits at less cost than Medicare fee-for-service.

So, it's not true -- and then you have to ask the question, well, if there's such a concern, why is there such a concern about premium support and Medicare losing enrollment out of the traditional program into the private plans if the private plans are so inefficient and can't have low premiums? In other words, I've always wondered, if fee-for-service is an option and it's competing on a level playing field with the private plans and it's the low cost provider, what's the concern? Wouldn't most people stay in the low cost provider?

I think the reason there's a concern is because they know that in many, many parts of the country fee-for-service is not the low cost provider. It's very much the high cost provider and there would be massive migration out of it.

So, there's lots of regional differences, but HMOs, on average, even with Medicare fee-for-services' tremendous advantages, which is it can dictate prices -- I wouldn't necessarily call that market power -- is, you know, the HMOs actually would probably come in less, that's been verified by the actuary at

the Medicare number and numerous times, and he'll do it again if asked.

MS. SAWHILL: Doug?

MR. HOLTZ-EAKIN: So, there is a clear divide that you're now seeing and, you know, Judy's vision of the future is one in which the Medicare program gets improved by all of the bells and whistles in the Affordable Care Act. I think Henry would concur. And I'm skeptical of that.

I think the road to healthcare hell is paved with (inaudible 0:18:56.7) and those will never turn into on the ground changes that deliver the care in the fashion that we all know needs to be. That's been the history of the program.

But neither I, nor anyone on this panel, should decide, so, instead what you see is, these proposals, Ryan and Wyden, Domenici-Rivlin, allow for the decision to be made by the American people. Put the best fee-for-service with all the bells and whistles out of the innovation center over here, put the premium support here, see which performs and let the American people pick. It's a very sensible approach.

And as for all the concerns you raised, those are all concerns that have been raised in Part D, all the selection issues, some people are sicker than others, it works fine, and this can work too.

MS. SAWHILL: Paul?

MR. VAN DE WATER: There's been a major piece of this discussion which has been missing this morning. Doug Holtz-Eakin almost got there, but not quite, and that missing piece of the discussion is revenues.

When the Rivlin-Domenici taskforce made its proposal for premium support, it was part of a comprehensive budget plan which had a

reasonable balance between spending reductions and tax increases.

That proposal had many attractive and sensible elements. In contrast, a lot of the proposals that we're seeing today for premium support, particularly those emanating from Congressman Ryan, and, in fact, from most of my pro-premium support colleagues here on this dais, are in the context of budget plans, which would rely primarily, if not exclusively, on benefit cuts, which would hit some of the most vulnerable people including Medicare beneficiaries, and are extremely short on tax increases, if any.

And I think we have to keep that in mind, that we have to look at the whole picture and considering the financial status of Medicare into the future, in the face of the large increase in the number of people, the per capitas that Judy talked about at the beginning, we need to have a revenue component as well as changes in benefit structure.

MS. SAWHILL: Stuart?

MR. BUTLER: If I could just pick up on the last question, first of all, it's correct. There is a subtext of this whole conversation about fee-for-service and coordinated care. I think if this was a medical conference and we were all physicians talking about this, I think there would be a general consensus that medically speaking, it actually is better to coordinate somebody's care than to have them wandering all around the health system, you know, picking their best shot with the yellow pages.

I think also, to take Henry's paradigm of the onset Alzheimer's person, I think it's kind of easier to decide to enroll for Kaiser as opposed to some other coordinated plan, than to figure out which primary care physician to go to and to look at their prospectus and which hospital, and so on. And so I

think that is part of it.

I think with regard to the premium support approach, it is a question of saying, keep this debate or this conversation, make the system neutral as to which way you go, and let other things determine that. That's why premium support systems should neither foster nor should it act against the fee-for-service system, and I think that's a crucial element in what you see in Rivlin-Domenici and in the Wyden-Ryan plan.

MR. AARON: As an economist, my union card says I have to like competition, and I do. That's one of the reasons I think the current Medicare system isn't so bad in that dimension. There is the potential for all the competition you could possibly want, since private plans, particularly incidentally, Jim, in high-cost areas, because of the way payments are set, could organize themselves and offer a product that people want to buy.

Now, so far, private plans have done that for little over 25 percent of -- about 25 percent of Medicare enrollees. To be sure, they've done that with the aid of about a 15 percent subsidy over the cost of fee-for-service medicine, but -- and it isn't clear whether they would have attracted so many people without that subsidy, but competition exists. It's not something that premium support would create.

If you like competition, we got it. Furthermore, I have no brief (ph. 0:23:41.5) with the fee-for-service system or for disorganized, fragmented medical care. The question is, how do we get from here to the improved delivery system on which I think all seven of us here emphatically agree?

There is absolutely no reason to believe that private insurance plans have any particular interest in moving us in that direction. They have not

been particularly effective in doing so apart from the flagship health maintenance organizations and Intermoutain and Geisinger that get trotted out all the time and that do provide high quality, comparatively low cost care. They're great.

They haven't, if you will, metastasized through the system unfortunately.

The real discussion here, and let me conclude, the real discussion here is who bears the cost from bad surprises if healthcare costs rise more than we think they will?

Under Medicare, they are diffused broadly through the system as a whole. Under premium support, they would be disproportionately imposed on the elderly and the disabled. That is, in my view, what the central issue that this debate is really all about and the division between the two sides on this boils down, I believe, to that point.

Finally, if any of you would like copies of Judy's, Paul's, and my comments, we have them in writing and would be glad to give them to you.

MS. SAWHILL: I think this has been a terrific discussion. Please join me in thanking all of these wonderful people.

(Applause)

* * * * *

CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Carleton J. Anderson, III

(Signature and Seal on File)

Notary Public in and for the Commonwealth of Virginia

Commission No. 351998

Expires: November 30, 2012