

THE BROOKINGS INSTITUTION

REFORMING MEDICARE:  
FISCAL CHALLENGES AND POLICY SOLUTIONS

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## P R O C E E D I N G S

MR. GALSTON: Good afternoon, one and all. I'm Bill Galston, a senior fellow in Governance Studies here at the Brookings Institution. I'd like to begin by welcoming everyone, including our C-SPAN audience, to this discussion of options for reforming the Medicare system.

The importance and timeliness of this topic should be clear to everyone. Medicare is a big piece of the health care sector, which now constitutes more than a sixth of the American economy. It's a cornerstone of security for tens of millions of Americans. The growth of this program, which will only accelerate as more and more baby boomers retire, is a prime driver of our long-term fiscal challenges. There's a lively debate as to whether the slower rate of growth in recent years means that we've finally turned the corner or rather will begin to accelerate again as we continue to recover from the great recession.

To explore these issues and possible responses to them we have, I am delighted to say, assembled an all-star cast. Their full biographies are available at this event and also online, so I'll just hit the high points in order of their initial presentations.

Robert Reischauer to my immediate left is president emeritus of the Urban Institute and a former director of the Congressional Budget Office, serves as a public trustee of the Social Security and Medicare Trust Fund.

To his left James Capretta, a former associate director for health care, Social Security education, and welfare programs at the Office of Management and Budget, is now a senior fellow at the Ethics and Public Policy Center.

To his left Christopher Jennings, formerly senior health care advisor to President Clinton, is now president of Jennings Policy Strategies and has recently served as a senior advisor to the Bipartisan Policy Center's Comprehensive Report on the

### Reform of the U.S. Health Care System.

To his left Joseph Antos, the Wilson H. Taylor scholar in health care and retirement policy at the American Enterprise Institute, has served as assistant director for health and human resources at the Congressional Budget Office and as a commissioner of the Maryland Health Service's Cost Review Commission.

And finally, Rhonda Randall, a board-certified physician in family practice as well as hospice and palliative medicine, serves as the chief medical office of the UnitedHealthcare Medicare & Retirement.

Each panelist will have 10 minutes for an opening presentation. A timekeeper in the front row will flash two cards: a two-minute warning and then time's up. Assuming compliance by all speakers, we'll then have a few minutes for discussion among panelists before moving to audience questions.

Three final preliminary points. First, and this includes the panelists, please turn off or mute any electronic devices that could erupt noisily during the proceedings.

Second, for the young and young of heart among you, you can follow this event on Twitter. The hashtag is #bimedicare.

Third, concern about the future of Medicare is widely shared not only in the country, but also within the four walls of The Brookings Institution. I'm happy to be able to spread the news that next Monday the Engelberg Center for Health Care Reform here at Brookings will release a comprehensive report created through broad consensus that provides a framework for aligning health care quality and financing reforms in Medicare as well as in Medicaid and private health insurance. This work is a continuation of the Bending the Curve series. Please check the website next week for the full report.

And without any further ado, on with the show. Bob?

MR. REISCHAUER: Thank you, Bill. I've been asked to set the stage by saying a few words about the fiscal challenge that is posed by Medicare. After that, I'd like to make four general observations that might help to provide a context for the remarks of my fellow panelists.

Medicare has been and will be in the future a major source of the growth of federal spending. The underlying reason for this is that health spending in both the public and the private sectors has been growing and is expected to grow in the future faster than either income or the economy. CBO has estimated that the growth of outlays for Medicare over the next decade will be about 22 percent. That is 22 percent of the total growth of outlays for the federal government will be accounted for by Medicare. And this is a period in which, largely because of the Affordable Care Act, the health reform act, per beneficiary medical spending is expected to grow at historically low rates, only at about 3 percent a year, which is roughly the speed at which we expect the per capita economy to grow.

A seeming contradiction between historically low growth and per beneficiary spending and the fairly rapid growth in overall spending is explained by the fact that with the Baby Boom generation reaching age 65 in droves, the number of beneficiaries is beginning to grow very rapidly. From the 1980s through the middle of the last decade, Medicare enrollment grew by less than 2 percent a year, and for big chunks of that period it actually grew at 1.5 percent or even lower. For the next decade it's expected to grow at 3 percent, or slightly above 3 percent, a year. Because Medicare spending grows along with health care costs, which, historically, as I said, have grown faster than incomes or the economy, Medicare spending is expected to grow more rapidly even after the Baby Boom generation are safely tucked into their retirement, when enrollment will plummet. It will be less than 1 percent a year after 2035 as a result of the

growth that's projected in the longer run future; Medicare spending is going to surpass Social Security spending by the middle of this century.

Because of the way Medicare is financed, we can't twiddle our thumbs as Medicare spending increases. The hospital insurance component of Medicare, which amounts to about half of Medicare spending, is financed much like Social Security: all workers pay payroll taxes into a trust fund, all employers pay the same payroll tax into that trust fund. And out of that trust fund comes all of the spending for Part A services, primarily hospital and insurance spending. The H-I Trust Fund, spending has exceeded revenues since 2007, and what that means is that the balance in the trust fund, the assets that are in the trust fund, have been declining and they will be totally depleted sometime in the middle of the next decade. Since the trust fund can't borrow, if current laws aren't changed, Medicare will be unable to pay full payments for changes in the H-I Trust Fund and will only be able to reimburse providers about 85 percent of what they're charging. So clearly some legislative action has to be taken before then either to raise taxes or to slow the growth in spending or, preferably, probably a little bit of both.

Now, by my reckoning, I've completed my assignment in under my allotted time. And rather than take a gold star, as I said, I want to make a couple of general observations.

The first of those is that as we have discussions like this, we should make clear what our goal is. If our goal is to moderate the growth of Medicare costs, whose costs are we talking about? Are we talking about the federal government's cost? Are we talking about the federal government and beneficiaries' costs? Or are we talking about the federal government's cost, the beneficiaries' cost, and the cost borne by states, localities, and private payers? In other words, when you talk about Medicare reform or cost saving, you can reduce the Medicare program's federal cost, but, at the same time,

increase the burden on beneficiaries or increase the burden on states, localities, and private sector payers, and, in fact, push up national health expenditures.

My second observation is that in our discussions we should clearly distinguish between true reform and traditional cost restraint measures. True reform changes the structure of the delivery system or the fundamental behaviors of providers, suppliers, medical researchers, and beneficiaries. True reform can save money over the long run, but it's unlikely that we're going to generate huge amounts of savings over the next decade from true reform. True reforms require institutional evolution, behavioral adaptation, and changes that are best introduced gradually.

Many of the suggestions that have been put forward to reduce the growth of Medicare costs are not true reforms, but rather traditional cost-saving restraint measures. They can generate quick savings, but those savings can be difficult to sustain over the long haul and may compromise quality.

My third observation is that we are unlikely to succeed in reforming Medicare without reforming the broader health care system. This is because Medicare beneficiaries receive their care through mainstream providers who practice one form of care in delivery systems that serve both private sector, Medicaid and Medicare, and the uninsured.

Finally, I want to say that many of the reforms that are being discussed might do more to improve quality than to reduce costs. While the current system is marked by inefficiencies, duplications, unnecessary and low-value procedures, and even fraud, there's also a lot of unmet need and an insatiable desire among the public for the latest and best interventions and the continued development of new devices, new procedures, and equipment, and all of that costs a whole lot of money.

MR. GALSTON: Well, thank you, Bob, for that exemplary stage setting,

exemplary in all respects.

Jim, the floor is yours.

MR. CAPRETTA: And he was well under budget, too. Thank you for inviting me to be a part of this discussion today. It's quite an important topic. I'm very pleased to be a part of it. I participated with my colleague, Joe Antos, down the dais here in a project that he helped organize that produced three papers that were released last week by the American Enterprise Institute. Joe, I know, will be speaking about one of them. I'm going to speak about the findings from the study that I did. There was a third paper from colleagues from the University of Minnesota, Roger Feldman and Bryan Dowd, as well as Robert Coulam from Simmons College. All of those papers are available on the AEI website and they're all related to today's topic, Medicare reform and its future.

My topic is the examination of Medicare's role in the broader health system. And specifically picking up a little bit on some comments that Bob just made, I want to talk a little bit about my view of how Medicare fee-for-service has broadly influenced the organization of American health care. In my judgment Medicare fee-for-service is the 800-pound gorilla of American health care. And unless it gets reformed, the broader system won't move in the direction we would like to see it move.

To begin, I'd like to start with the metaphor that Bob essentially alluded to. I put in a slightly different terms. I think the prevailing view is that the health care system is something like a runaway cost train heading down the tracks at a very accelerated rate, and Medicare is sort of one car attached to this very, very rapid runaway train. And, therefore, to slow down Medicare, you've got to slow down the whole train. Otherwise, you're picking out one portion of it. That could create inequities. Probably wouldn't work if you just focused on one part of it, et cetera.

I like to take exception to that sort of metaphor and think, well, what if Medicare wasn't just one car attached to this train, but actually was the engine at the front of the train pulling the rest of the cars down the track? Or if not the only engine, at least one of the primary engines of the train. And if one thinks of Medicare in that kind of a context, then you say, well, wait a second, maybe we need to focus a little bit on Medicare and its role in American health care first and foremost. And that's actually one of the points of my paper.

To begin, Medicare is the largest single payer in American health care. Of course, in any given community the combined buying power of various employers in a marketplace might exceed the value of Medicare's purchasing power, but they're dispersed and they don't act as one. Medicare's a single purchaser with a single regulatory structure, so it is the single largest actor in any given marketplace. If you look at the national health expenditure data, Medicare is roughly a little bit more than 1 out of \$5 of personal health spending. But I think that understates Medicare's role quite substantially.

First of all, even in that accounting, private health spending that wraps around Medicare is counted as private insurance, not public insurance. So, for instance, Medigap plans and employer wraparound plans, which are really just add-ons to Medicare and don't influence the delivery of care, those are counted as private spending. So if you pull back from that and actually look at the national health expenditures by age, roughly 1 out of \$3 is for the population aged 65 and older. That's quite substantial. And then Medicare's influence goes beyond that to the disabled, who are on the Medicare program as well. When you put those dollars in you're getting close to about 4 out of \$10.

Furthermore, Medicare's regulatory payment structure is widely used by



the broader system, in part due to the recognition that the delivery system becomes accustomed to it and other private payers piggyback on top of it. So if you look at private insurance, of all the insurers that are out there offering coverage three out of four of them in at least one of their main plans is offering a plan that is piggybacking on Medicare's fee schedule for physicians. Now, that doesn't mean they use every dollar amount that Medicare uses, but they use the structure and they add on to it or adjust it to some degree.

And, of course, Medicare's DRG system for paying inpatient hospital services is widely used by every payer pretty much in the country. So when Medicare makes a change, the whole system changes in response to that. So Medicare's influence goes well beyond even its size, even though it is also obviously the biggest player.

Now, the next point to make is that Medicare is a fee-for-service program by and large. Three out of four beneficiaries in the program are in the fee-for-service system. And it was designed in 1965 to mimic the prevailing insurance of that era. Fee-for-service insurance is essentially a claims-paying operation. That is, a licensed medical professional submits a valid insurance claim on behalf of a service that provider has rendered to a patient, the insurer in this kind of insurance system is, in a sense, obligated to pay the claim if it's a legitimate medical service. Medicare has essentially operated that way and still essentially operates that way today. Now, there are some exceptions on the margin, but by and large it's a claims-paying operation that they're trying to move away from, but really very slowly and very modestly.

The only way this kind of insurance plan ever really works is if you have patient cost-sharing at the point of service. If you have a system where the insurer's paying any claim that is filed by any provider that's licensed and legitimate, the only way

to have any check on use of services is if the beneficiary population pays a portion of the cost at the point of service, so that they think twice is this a legitimate thing that I really need, and the patient has some responsibility. Therefore, there's a little bit of a check on saying, well, let's not just use everything. Let's think about this twice before we do so.

In Medicare, however, patient cost-sharing is quite large in the statute. There's an inpatient deductible, there's an inpatient co-insurance rate, there's actually limits on the number of days you can stay in a hospital, there are physician co-payments and deductible. All of that is largely rendered useless because of wraparound insurance. For the vast majority of beneficiaries that participate in Medicare fee-for-service they have either Medigap supplemental insurance, about 25 percent; or they have an employer wraparound plan, about 40 percent; or they have Medicaid, roughly about 20 percent. When you put it all together, essentially -- and there's a couple of others -- about 9 out 10 fee-for-service beneficiaries pay 0 or near 0 at the point of service for the health care costs. So you have a fee-for-service insurance system where the beneficiary population is not sensitive by and large at the point of service. It's very, very predictable what will happen, which is there's huge volume increases in Medicare and have been for a very long time.

CBO did a study looking at physician services between 1997 and 2005. It showed that overall there was an actual real cut in the per-service payments from Medicare to the physician community, 5 percent, which is pretty remarkable. They paid the physicians less on real terms in 2005 than they did in 1997. But overall, physician service costs went up in real terms by 35 percent. And the reason was volume and intensity of physician use, physician service use, went up by 40 percent during that 8-year period. Pretty remarkable actually because then you dig into the data and you say essentially what it implies is that the beneficiary community was using and needed 40

percent more services for their care 8 years later. That's a very unlikely occurrence. So there's lots of volume in the Medicare program.

A third point would be that when you look at Medicare and its influence, you can see the inverse of it by looking at when there is large penetration from the Medicare Advantage program, especially the HMO program. Several studies have done, and a recent one done by Michael Chernew and others, indicates that when you have large Medicare Advantage penetration in a Medicare marketplace it turns out that fee-for-service costs actually go down, not just Medicare Advantage costs. And that's because Medicare Advantage, at least in the HMO part of Medicare Advantage, does have some incentives to change the practice of care by the physician community. There have been several studies that show that that spills over and influences how fee-for-service physicians actually -- or how those same physicians take care of their fee-for-service beneficiary population. I think that's another window into Medicare fee-for-service's role in how it influences the delivery of health care.

Finally, before turning it over to Chris, the one study indicated that between 1950 and 1990, there's a very, very large increase in the supply of medical care in the United States, all to the good basically. Basically a 600 percent increase in real terms in the per capita use of medical care in the United States; the vast, vast majority of that was very good.

But if you dig into it and examine where did all that come from and who paid for it and who incented that very large buildup of a medical delivery system, Medicare fee-for-service was at least one of the two top reasons. The second being open-ended tax subsidization of employer-paid health insurance.

So I don't think we're ever going to get at the problem of delivery of medical care in the United States without seriously addressing Medicare fee-for-service.

Thank you.

MR. GALSTON: Thank you, Jim. Chris, over to you.

MR. JENNINGS: Well, thank you. And Bill, thank you for inviting me. I'm here, I guess, in relationship to my advisor status to the Bipartisan Policy Center and my remarks are oriented in that context.

First, last Thursday, the Bipartisan Policy Center did release a report entitled, "The Bipartisan Prescription for Patient-Centered Care and System-Wide Cost Containment." It really was the outgrowth of an intense nine-month effort working with Senators Daschle, Domenici, Frist, and former Director of OMB and CBO Director Rivlin, who is also a fellow here at Brookings, to work to see if they can do a combined effort that was focused on both health care and budget pressures to produce a policy that was very focused on how we improve care and quality in our health care delivery system. All the leaders felt very strongly that our work had to be grounded on improving the value proposition, that our return on investment in this country was indefensible, and, most important, we are not serving well the patients who enter our health care system.

We released a four-pronged set of integrated policies. It included reforms of Medicare, tax exclusion policy, prevention and wellness, state-based reforms dealing with Medicaid workforce, and medical liability challenges. Suffice to say, I'm not going to go through all that. And I have been asked by Bill to focus on the Medicare reforms.

Anyone who has an older father or mother, as I do, or has experienced the health care system for themselves or their children well knows the frustration of navigating through our health care system. It's complicated, silo-ridden, air-prone, and uncoordinated. Of that there can be no doubt. Physicians and other health care professionals responding to, yes, flawed incentives, predominantly in our fee-for-service

systems, are penalized for spending more time with patients and yet rewarded for ordering unnecessary and sometimes dangerous tests and procedures. None of these frustrations translates into better care and, as such, our leaders directed us to develop policies that were patient-focused and health care practitioner-empowering. Federal and private sector savings would be a desirable outgrowth, but it was not to be the driver of our work.

And by the way, I should just say that if you're going to take on the health care reform issue in this country, if you focus on any other approach, then I can absolutely guarantee you that you will not be pursuing sound policies or politically viable approaches. So rather than embracing a series of one-off policy proposals that may be justifiable on a case-by-case basis, we constructed a vision that would have a meaningful impact on how we deliver care. We were very focused, by the way, in that context to not embrace policy that has merely just shifted cost to other purchasers.

Fully recognizing that conservatives have major concerns with traditional Medicare, and progressives have major concerns with premium support policies, we tried and believed we succeeded in finding an approach that takes some of the most valuable components of both. We accept that the current fee-for-service program is flawed for the obvious reason: it drives up volume with little correlation to quality and value. We also accepted that most Americans were very concerned about shifting insurance risk and possibly cost to beneficiaries within the context of most traditional premium support proposals.

So our policy envisions strengthening and modernizing the traditional Medicare program and Medicare Advantage by creating incentives and rules to encourage competition choice and much greater and coordinated care in a fashion that is designed to improve care and quality. So how do we do this? Three ways.

First, our approach embraces a number of policies that many health care experts have advocated as a way to transition away from the traditional fee-for-service program. So we do support bundling reforms, competitive bidding reforms, sight-of-service reforms as a significant, but short-term down payment to help transition to a more coordinated system.

Similarly, we do embrace an income-related premium that we believe does improve upon the administration's income-related approach that was just unveiled in the President's budget. We make certain that the subsidy for all beneficiaries never declines below 20 percent. In the administration's it actually goes down to 10 percent, and we're concerned about people opting out of the program and having selection issues.

Within this context we also embrace an improved low-income subsidy program dealing with the purchase of prescription drugs. In this population we have a lot of older but low-income Medicare beneficiaries who are underutilizing low-cost generic drugs relative to the rest of the population. So we designed a cost-sharing mechanism that eliminates cost-sharing for the use of generic or other low-cost products and we cap the federal reimbursement rate to providers of those drugs to ensure that we get a significant uptake in the use of those products. The consequence is that we get over \$40 billion in savings over 10 years.

Okay, secondly, we strengthen and improved the Medicare benefit by bringing it into the 21st century, and this addresses something that we just heard about relative to the need for the modernized benefit. We do finally extend new catastrophic coverage benefit for seniors. We all know in this room that we don't have catastrophic coverage in the traditional Medicare program, and we do so in a budget-neutral level by combining the deductibles A and B and having a one deductible \$500. The catastrophic cap is capped at \$5,300, a little bit over \$5,300. That is budget-neutral.

That is not so new relative to other policies, but what is new is that we do have an elimination of physician services applying to that deductible. In other words, the physician services, you have to pay the co-payment, but the deductible does not apply. That addresses a very real concern.

Oh my gosh, I have two minutes left. Okay. So we do other things, which I won't talk about. (Laughter)

So third, and probably most significantly, we really alter the incentives in the Medicare program, and I hope we have a little bit more time to talk about this, by really accelerating the movement towards ACOs, accountable care organizations, but we call it and we perform it substantially by addressing some of the shortcomings of these policies. One of the shortcomings, of course, is Medicare beneficiaries don't even know that they're in ACOs now; they're just attributed to the program. Physicians don't participate in any significant way. There isn't two-sided risk. The policy is designed to accelerate movement into these Medicare networks and reform what we do with the MA program.

How do we do this? Well, on the MA side of it we have competitive bid for MA programs, straight up, delinked from the fee-for-service program. On the Medicare network side of it, in order to facilitate Medicare beneficiaries moving to what Jim was talking about, moving from the fee-for-service to the Medicare networks, we do freeze payment rates for all fee-for-service providers and then we provide those updates for those providers if they go into the network. So, in other words, you're going to be frozen at SGR levels for a physician, and for hospitals and others within the fee-for-service level you will be paid, but your payment rates will be frozen, so you'll have financial incentives to go and deliver in those programs. We can talk about the implications of that later, but we think it's a really important innovation.

So since I have no time left let me just aggregate what all this does in savings and, hopefully, we can open up for questions. We do believe that the combination of all these incentives will improve care and focus on quality. The aggregation of this is about \$300 billion in net Medicare savings inclusive of the low-income protections that I mentioned to you as well as reforming the SGR, the physician payment reforms. So that is net of \$300 billion, a significant contribution to deficit and debt reduction, but, much more importantly, a significantly enhanced and improved health care delivery system that works to the benefit of the beneficiaries.

I'd like to talk to you more about that, but my time is up. Thank you.

MR. GALSTON: Well, Chris, thanks so much. I suspect you'll have a few more bites of this apple before this session is over.

Joe, over to you.

MR. ANTOS: Thanks, Bill. The overall title of our series of papers at AEI is -- I just happened to notice this sitting here -- "Preserving Medicare for Future Generations: Market-Based Approaches to Reform." But preserving Medicare doesn't mean keeping it unchanged. In fact, to preserve Medicare change is inevitable. It would be better if it were a conscious change, if it were something that we wanted to do, rather than something that happened.

I think the critical element here is to reform the program in a way that changes the incentives that face both consumers or patients and health care providers. Bob happened to mention in his opening remarks something about the insatiable desire of patients for new medical treatments. There's a lot of truth in that if you don't have to pay for it or you don't think you're paying for it. I think a good question is where can consumers effectively exercise their judgment, ideally an informed judgment, better informed than we now have? Where's the best place for consumer action to fall?



And I'd say that in spite of the availability of my favorite medical advisor - the Internet -- probably my doctor has an advantage over me in discussing treatments that I might or might not get. And I might find something great that looks terrific, but it might actually be completely wrong. And ideally, my doctor would tell me that's not a good idea.

So where consumers can make a decision effectively is really with regard to their choice of health plan. Again, if you have good information it is possible to choose a good plan over a worse plan for your personal circumstances. But we also have to change the incentives facing my physician. He needs an incentive to not only give me good medical advice, but also have some awareness and concern about the overall cost of my care. In other words, he's really going to be there and my health plan is going to be there making a lot of decisions that I'm not going to have direct control over, but that will influence not only my care, but the cost to me and the cost to everybody else. And that's true in the private health sector, that's true in Medicare as well.

So, you know, Medicare is obviously critical to the wellbeing of 50 million seniors today and will be critical to the wellbeing of a lot more people in the coming years. I think the question for me is whether, in fact, we can go in the direction that Chris mentioned in a very, very abbreviated fashion at the end. Can we do that in a more effective way? Can we move in a direction of better competition among health plans in the Medicare program? And how far can we move in that direction? And, of course, do partial measures work? I would argue that partial measures, such as the proposal made by the BPC in that regard, really will not be effective.

So full competition, what does that mean? Some people want to call it "premium support," which has become a bad term and I probably shouldn't use it, but I

will slip into that terminology from time to time. The kind of competitor forum I'm talking about goes beyond the simple idea of competing health plans. It also involves changing the way the traditional Medicare program operates. And in that regard, in some ways, there's some similarity between what I would recommend and the BPC's recommendations.

But I think the key element here is that effective competition involves all the health plans, not just some of them. In fact, what we now have in the Medicare Advantage program is competition that only involves the private plans and Medicare. It does not directly involve the traditional Medicare program. The private plans bid against a benchmark. For quite a few years now, the benchmark was set at a level above the cost of fee-for-service Medicare. And guess what? Not surprisingly, the plans bid pretty close, generally, in most areas, **bidg** pretty close to what the government promised they would get paid.

In other words, if the competition is set up, if the bidding is set up so that the government is telling you, the competitor, what it is willing to pay, well, that might influence your bid. Probably you won't get the lowest possible bids. Probably you won't get the strongest incentives for efficiency. And, indeed, I think that's precisely what's happened over the years in the Medicare Advantage program and traditional Medicare.

So the idea behind a full competitive model, a premium support model, is to have all of the plans bid, including traditional Medicare, including a reformed traditional Medicare, which I will address very, very briefly at the end. The idea behind the bidding is to reverse the flow of information from the way it is now where the government basically tells the plans what it's willing to pay and instead have the plans tell the government what they think it's going to cost to produce a fixed benefit.

Now, some people want to believe that premium support kind of gives

people vouchers and sends, you know, your grandmother out into the very difficult health insurance market without any information and without any protection. That's not a reasonable reform and I think most proposals would comport with what I'm about to suggest, which is that instead the bids would be on the basis of the full Medicare benefit, whatever that turns out to be. It could be the one that we have today. It could be an enhanced benefit. It could be a slimmed down benefit. But it would be -- the plans would bid on the basis of the same benefit.

The private plans would be able to enhance that benefit if they wanted to. They would obviously enter the cost of their bid. But they would have to bid on the basis of the basic Medicare benefit. So that's one protection.

Obviously the Medicare program currently and in the future would certify the plans that are bidding. It basically would provide that protection to seniors to be certain that the plans that they are considering are not only legitimate plans, but, in fact, can follow through on access to the services that are guaranteed under the Medicare law. So it's not quite sending someone's elderly relative out there to fend for themselves. Indeed, it's very much in the spirit of markets that have a reasonable degree of regulation.

So from there, then, I guess the question is will it work? The current system, obviously fee-for-service, an unlimited subsidy to the health sector. I like to emphasize that it's the subsidy to the health sector because, when you think about it, the average Medicare beneficiary doesn't actually see a dollar. It's either sent to the providers directly or sent to the health plans that they signed up with the Medicare Advantage plan. So the subsidy is really to the health sector. And if you don't change the terms of that subsidy, you won't get changes in the way the health sector operates at least in the Medicare program. But, as Jim said, if you change Medicare, you're likely to

have ripple effects that could be very positive for the rest of the health sector.

So the question is, can you get it to work? And in particular, do you need a cap on overall spending? I would argue that budgeteers want to have caps and budget overall spending because you get a good CBO score that way. But, in fact, that's really the wrong way to go because that's kind of the system we have right now. That's the top-down approach. And, in fact, the idea behind a competitive bidding structure is to get information out of the health sector rather than to give them the price that they can somehow learn to live with.

The question about what the subsidy should be is a difficult question. It could be tied to some combination of the low bids, for example. But the question is "tied to" isn't the same thing as "exactly equal to," and I think that's the political question that has to be addressed. It's a separate question from getting the information about what a Medicare plan costs, but it is a very important political question that will inevitably be addressed. It is largely avoided in political discussion, but we won't be able to avoid it forever. So I would argue that having a top-down cap is a terrible idea.

The question is can it work? We know a couple of things about whether it can or cannot work. People always point to the Medicare Part D program and point out the fact that Part D spending has been much lower than originally projected by CBO. Of course, that does say that CBO is not a fortune teller, at least not an accurate one, and projections are fairly faulty. But, in fact, that program has done better in terms of per capita prescription drug spending than the rest of the country, so that's a pretty good indication.

And then I guess the last one that I wanted to mention is, do seniors make good choices? This is a fear that everyone has that somehow people wouldn't be able to select a good plan. And so here I want to go to Part D again. And what a lot of

analysts who don't like the idea have said is that in the first year of Part D, Medicare beneficiaries didn't pick very good plans. In other words, they paid more than they needed to.

There's a recent study published in the *American Economic Review* called "Sinking, Swimming, or Learning to Swim in Medicare Part D." And what it says is something that is heartening I think for all of us, me especially. It says that when you turn 65, you don't lose your ability to think. And so what basically happened was, not surprisingly, the first year of Part D was pretty confusing for most people. The second year they looked around and they said, well, maybe there's a better option. It seems kind of expensive. And indeed, for a very, very large sample the average gain from shifting plans from 2006 to 2007 was \$298 a year. That's a pretty good indication that consumer choice can work if it is funneled in the right direction.

I don't have time to talk about other reforms in Medicare. I largely agree with the general direction of the BPC's suggestions, which I guess you didn't talk about either. Okay.

MR. GALSTON: Thanks, Joe. Dr. Randall.

DR. RANDALL: Good afternoon. On behalf of the UnitedHealth Group, I'm pleased to be a part of today's panel to discuss the need to reform the Medicare program.

My professional career has been dedicated to the health and wellbeing of seniors. After finishing my fellowship in geriatrics, I worked in private practice, taking care of hospice patients in their home and long-term care in nursing home settings. Today I'm responsible for managing the clinical strategy for UnitedHealthcare Medicare & Retirement, a business of UnitedHealth Group that is dedicated to the health and wellbeing of more than 9 million people, nearly 1 in 5 Medicare beneficiaries.

My co-workers and I are committed to our mission to help people live healthier and more secure lives. And on a regular basis, we're collaborating with health care professionals, physicians, and the federal government to identify new and innovative ways to serve Medicare beneficiaries, which is why I think today's gathering is so important. Because to seize this opportunity and to overcome the many challenges of our country's aging population it's going to require an interprofessional team, the contribution from the local primary care physician to the social worker visiting people in their home, to the federal government, to policymakers, and to the largest insurer in the country.

It's an exciting time to work in this field. The population that we're serving is growing at a tremendous pace as baby boomers age into their golden years. And we're in an important place in our company's evolution and in the history of Medicare. These leading-edge boomers, those who aged into Medicare over the past two years as they're sometimes called, represent the beginning of an epic wave of growth. The statistics were mentioned earlier. By the end of the decade, this decade, 64 million people will be enrolled in Medicare. That's about 14 million more or 28 percent more than are enrolled today.

In addition to their exponential growth in size, the Medicare population will also look and act very differently as the boomers age in because of their unique qualities and characteristics. We fully expect them to interact with the health care system very differently than their parents' and grandparents' generations did. So for companies like mine this represents a dual challenge and an opportunity not only to serve a much larger population, but to tailor our plans and products to meet the unique needs of the growing Medicare beneficiaries. So I'd like to share with you today a little bit about what we've learned so far from our members who are baby boomers and their diverse

characteristics.

They are very interested in managing their health and making the number one choice as they age will be for their Medicare plan. I emphasize consumer choice because that's really what boomers are all about. We don't expect them to change their buying habits just because they're turning 65. At the core boomers are shoppers. The dynamics of their youth and working years shape them into status-conscious, sophisticated buyers. So rather than sticking with the tried and true, we expect that they're more likely to switch products if they don't find one that meets all their needs.

This level of sophistication and refinement in their shopping habits has spilled over into health care as well. We fully expect them to apply those same habits into choosing their Medicare benefits. They will have high expectations for personalized health care. A one-size-fits-all approach is unlikely to satisfy them. At UnitedHealth Group we've spent the last several years preparing our Medicare organization for that dramatic shift, and we're already seeing the change. We currently have 1.2 million boomers with birth dates of 1946 to '48 enrolled in our Medicare products. But the majority of our experience with the baby boomers actually lies in our employer and individual business, those who are today in the workforce purchasing health care either as an individual or through their employer.

Younger Medicare-eligible consumers are demanding more customization and access to products and information that give them more control over their own health care. We fully expect that this is just the beginning of a broader trend. Boomers are going to expect and, indeed, demand more from their health care programs. The boomer beneficiary will not hesitate to dis-enroll if their plan is not meeting their needs. So we see these consumer preferences having a positive impact and driving

competition and innovation. We are well positioned and ready for that shift in health care.

We also know that boomers are expecting to live longer than their parents, and studies show us that they will live longer than their parents. To do so they will need to actively manage their own health. This expectation of living longer in some respects runs contrary to the reality for aging boomers, most of whom will live with at least one chronic condition as they age.

That leads me to my second point. The boomers will challenge our health care system not just because of their numbers, but also because of the struggles that they will face as they live longer than generations before them. Their health care conditions will be more extended and more complex than those experienced by previous generations. So today, if you're 65 or older, you're more likely than not to have at least one chronic condition. Two-thirds of adults over the age of 65 fall into this group and three-quarters of adults over the age of 80 fall into that group of more than two chronic conditions.

The reality is that chronic conditions are the biggest driver of health care costs and decreased quality of life. The size of the boomer population is only intensifying the pressure to identify new approaches to help ease the effects of chronic diseases and their associated cost.

We also know that the largest driver of chronic conditions is lifestyle choices. Sedentary lifestyle, obesity, smoking leads to conditions like diabetes, heart disease, cancer, and others. So we know that transparency tools and incentive programs will be a key component to helping people choose healthier lifestyles.

So we think because of all this there's an incredible opportunity for Medicare to evolve in a way that allows for seniors to access higher quality care at lower cost than they're able to do today. And we look forward to partnering with the federal



government to bring out that innovation in years to come.

Medicare Advantage has a strong record of pioneering new innovations and strategies for improving the health care quality and promoting efficient delivery of the health care services and advancing an evidence-based health care system. For example, a model of care called Evercare is embedded in Medicare special needs plans today. This was a program that was invented by two nurse practitioners who were working in a nursing home and found that the quality of care and the outcomes that their patients were receiving was suboptimal. They knew that they could take care of individuals who were typically shipped out to the hospital better and more effectively if they treated them in place with the skills and the qualifications that they had in the nursing home. That model became a permanent part of Medicare in 2006 with the special needs plans, and it's been shown that more effective primary care can save costs by reducing unnecessary hospitalization.

The same holds true for members with diabetes. More effective management of their care can improve outcomes. There was a study published in Health Affairs last year that demonstrated that individuals who had diabetes, when they were seen in their home by a nurse practitioner who did a comprehensive assessment and helped to get their care coordination started, a full physical examination with a component of asking about their medical health, their social history, and their behavioral health, increased primary care visits significantly and decreased unnecessary hospitalizations and readmissions.

So the Medicare program offers a solid foundation of proven solutions for modernizing the broader Medicare program to meet the health care needs of current and future generations. And so we look at this as two sides of the same coin. From one side the consumer choice and sophistication and from the other side an unavoidable truth that

the rising medical costs related to chronic conditions will continue to have a significant impact on the Medicare Advantage program.

The most viable way to achieve sustainability is by addressing rising medical costs through improving health care quality and engaging consumers to become more activated in their own care. People with diverse backgrounds and professional responsibilities are gathered in this room right now. So if you look around, probably the person sitting next to you has a very different job than you do. And it's going to take all of us, all of the sectors of society, working together constructively if we're going to innovate the kinds of solutions that will be necessary to serve boomers as we age.

We believe the private sector plays an essential role in both sides of this equation and we have the data that illustrates our success in helping beneficiaries improve their health. In partnership with the federal government and with health care professionals we are transforming the way that health care is delivered in this country. So we're excited about those possibilities and we look forward to continuing to play a role in the changing health care in this country.

So on behalf of UnitedHealthcare, thank you.

MR. GALSTON: Well, let me take this opportunity to thank all of the panelists for their concise and very well-focused presentations.

Here at Brookings, despite our different disciplinary backgrounds and our different orientations on policy matters, there is one belief, you might even call it an article of faith, that unites us in this building and a common mission, and that is -- you can call it Jeffersonian naïveté if you want -- that democracy does not work well unless and until the people themselves understand the real choices that they confront as citizens and we confront as a country. And I believe that what you've just heard in the past 50 minutes constitutes a superb introduction to one of the most important policy problems we face.

And I'm grateful to the panel for getting us off to such a strong start.

Now, I'm going to struggle to be a moderate moderator here because I have all sorts of questions that I'd like to put to the panelists, but I know that they have questions that they'd like to put to each other and that you have questions you'd like to put to them. And so I'm going to suppress my questions and begin by issuing an invitation to each member of the panel, and please be brief and pointed in taking up my invitation.

If you've heard an important proposition put on the table in the past hour with which you disagree, would you state that proposition and who put it on the table and why you disagree with it? And we can go from there.

(Laughter) Everybody agrees. Well, I have a list, but if nobody else -- who wants to start?

MR. REISCHAUER: No, there's rampant consensus here. (Laughter)

MR. GALSTON: Well, I'm not so sure. Chris?

MR. JENNINGS: Well, you see, I'm in my bipartisan mode here because -- so I have to be, you know, somewhat constructive. (Laughter)

MR. GALSTON: There's a "but" lingering in the air.

MR. JENNINGS: But, I mean, you know, I think really one area that I'm not sure I would say I disagree, but I do think that one of the challenges with the MA policies in the past really have been that notwithstanding the fact that they do have some innovative approaches to managing costs, they haven't shifted those savings to the program in any significant way. In fact, it's increased costs notably to the Medicare program.

And, you know, one area that I believe that is really important to talking about modernizing the Medicare program is ensuring that Medicare beneficiaries feel that

they have a choice of where they want to go and they're comfortable with those choices and they do not feel substantial disruption. I think if we went to a straight-up premium support or if we relied totally on a fee-for-service, we would have some major problems both in terms of cost and as lost chances in achieving savings. So our motto, which I hope we can talk to a little bit later, is really an attempt to take advantage of both of those and address both shortcomings.

And I think this sort of premium support-only model would create the type of disruption and wouldn't guarantee the type of quality that we'd want to see in the program. And I think it would also shift significant cost risk to beneficiaries. So the hope is that we can find a balanced approach to doing this as, by the way -- I'll just underscore -- that if we went to a fee-for-service approach and maintained fee-for-service, it would continue to drive up costs and we would have the problem on the volume side. So really we're just trying to get to a balanced approach. And I think that the initiative that we've laid on the table last week attempts to do that.

So, again, we critique in a very significant way the fee-for-service as it exists as we do the shortcomings of what we perceive to be the premium support policy.

MR. ANTOS: Well, so, again, what I was talking about was not the kind of premium support policy that Chris and a lot of people who don't like the slogan often characterize. So as I tried to make clear, the Medicare program, it's still going to be Medicare subsidies, the government is still going to have responsibilities to ensure that the plans operate in an appropriate manner and take action when -- in the few cases that that might not happen.

As far as the program shifting costs to the government, the Medicare Advantage program shifting costs to the government, that was a conscious political decision. And its roots are back in 1997, when I believe it was a Republican Congress

was on a cost-cutting move and it severely cut payments to private plans in Medicare and half the plans dropped out within three or four years. So in 2003, again, I think a Republican Congress, in passing the Medicare Modernization Act, they built in this guaranteed -- relatively guaranteed payment that was at least as high as traditional Medicare and oftentimes higher.

That's not what a sensible competitive bidding process does because that -- as I say, that is basically a top-down approach that is telling the plans here's how much money we're willing to offer you. In fact, it's a lot more than you thought before. Would you like to bid? And indeed, it worked from the standpoint of increasing the number of plans available, but it didn't balance appropriately government cost with these options for beneficiaries. Beneficiaries who signed up for these plans tended to get a much better deal, tended to get extra benefits, tended to have lower costs. That's no lie. But the third party in this, the taxpayer, was indeed overlooked.

MR. GALSTON: Well, I have -- you know, first of all, I think Bob was certainly on to something, you know, when he uttered the phrase "rampant consensus" because there is, I think, a very important analytical point that is shared across the panel, and that is that the fee-for-service model of medical payments is a very shall I say suboptimal way of organizing a payment system and it helps to catalyze a suboptimal way of thinking about health care delivery. That's important. And I suspect that most people, regardless of their political or policy priors, would probably agree with some form of that statement.

I guess the question that I want to put on the table, and it's a question that appeared to me to be at issue, to some extent, between Bob Reischauer and Jim Capretta, is when you look at Medicare as part of the overall health care system who's in the driver's seat here? You know, Jim said Medicare understood correctly is the engine

for a lot of the features of the health care system that we don't particularly like at this point and may not be able to afford in the long run. And he said that Bob had a different analytical take on the relationship between Medicare and the overall health care system.

So it sounds to me, Bob, as though you deserve a chance to respond.

MR. REISCHAUER: You know, I hope Jim won't disagree with me, but I think it's a two-way street. And, you know, the private sector affects Medicare, Medicare affects the private sector. And you can get hung up on, you know, which impact is larger.

I think when we're talking about all of this what we really want to be focusing on are the three dimensions of importance. One is cost, but the second is quality of care and the third is innovative ability. And, you know, a fee-for-service, I think unrestrained fee-for-service loses on cost. It loses on quality because it's very difficult to integrate care and manage care with, you know, we have lots of little different providers that aren't cohesively operating and coordinating their care.

On the other hand, it's great for innovation because, you know, we basically have, you know, an open spigot. You know, go out and invent something, claim it improves care, it will then get approved. And even if it improves care very marginally and only for some of the people, we'll pay for it. But a thousand flowers bloom and a few of them are pretty. (Laughter)

And, you know, one worries that under a premium support system -- and, you know, I confess sympathies with rightly done premium support and I share the same criticism of wrongly done premium support that Chris has -- you know, there might be a problem with the amount of innovation that takes place. Because even in a competitive world, entities that are large and compete with each other often mirror each other's behaviors as opposed to going off on a new tangent because that's high risk and you have a lot at stake and don't engage in it.

So I think, you know, there's no right or wrong answer to this. It's a matter of weighing these three attributes when you think about how you want the system to reform. But I think even the staunchest defenders of fee-for-service believe that changes are needed to introduce more in the way of coordination that will improve quality over time.

MR. GALSTON: Jim, would you like to respond to that? And then we'll go to questions from the audience.

MR. CAPRETTA: Yeah, I'll be very brief. Yeah, I basically agree with what Bob just said.

The reason I brought up the metaphor at the beginning and to make the point is that there have been -- and I think it has shifted in recent -- probably in the last couple of years, but there had been a prevailing view for, in my time in Washington, 15 or 20 years that some would say, you know, we don't really need to fix Medicare. Medicare's buying from this larger system. What we need is cost containment of the whole system. And they would miss this very important point that Medicare is a big part of the reason why the system is organized the way it is and you might want to focus in on what Medicare's doing to influence the organization of the existing system. I think there's more recognition of that now than there had been in the past, frankly, and I think that's a good thing.

One just subtle thing about -- I think, you know, why one might think of the difference between what Joe has put forward, which I support, and what Chris has put forward, I think it's a question of how one views the likely success within our current political economy and how Medicare is run. I mean, Medicare looks the way it does, in a sense, for a reason: because our political system kind of likes the way Medicare fee-for-service looks and operates. And the question is how can you break that cycle?

And, you know, with the level of familiarity I have with the Bipartisan Policy Center, I think they're generally interesting recommendations, but they rely quite heavily on the CMS and the federal government sort of managing this transition to a more effective delivery system. And I think Joe's approach and the one I support relies much more on a system where the government can't mess it up again and the consumers will select, with the proper incentives, the highest-value delivery system if they're properly incented to do so.

MR. ANTOS: You got my juices flowing, I'm sorry.

MR. CAPRETTA: Good, good.

MR. ANTOS: You know, you can overemphasize how much Medicare can influence the rest of the health care sector because there really isn't anything like Medicare. Medicare, as you say, in 1965, did resemble private employer-sponsored health insurance, but it sure doesn't now. I mean, there is nobody in the employer-sponsored health insurance world or in the individually purchased who is on an unmanaged fee-for-service system. Everybody has a network. Everybody is intervening in some way to steer or manage patients.

There isn't another system where there's administered prices. And this is because, as Jim says, Medicare is the 800-pound gorilla and it can go into the hospital and it says this is the price. It's set nationally. We adjust it a little bit for price differences across the country, but take it or leave it. And if you leave it, you don't get any of our business, and that's too big a chunk for any provider except boutique providers to face up to.

Medicare has tremendous political advantage in that it gives consumers the most choice anyone could have. And when you have the most choice anyone could have, you can't be unhappy, you can't criticize. The decisions you make, which result in



some pretty poor quality often, are your responsibility. They aren't UnitedHealth's. They aren't a plan's. And so both from -- and if you're a single payer, it's the government's fault. If you're in a managed competition kind of situation, it's the plan's fault.

And we're hesitant, I think, to move in that direction, but this, I think, is changing generationally, as Rhonda said, that, you know, we have probably a preponderance of elderly now who still remember the old Aetna and Blue Cross systems where you could anywhere and there was no management or anything like that. Younger generations are in plans with networks, with huge penalties if you go outside the networks, where they have restrictions on exactly what kind of services are covered. You know, is it 30 group sessions of therapy or is it, you know, 15 individual sessions? You know, changes like this. We're used to that as opposed to I'm just going to keep going until I wear out, you know.

And I was in a situation, I can't name names, but an individual who used to work with me had a problem and he goes into the emergency room of one hospital. And, you know, they said can't find anything wrong with you; spent overnight; still hurt the next day. Went into a different hospital, did the same thing, you know. And went to a third hospital the third night. So he had three nights in the hospital, Medicare sort of paying for each one of them. Turned out to be the Mexican dinner he'd had four nights ago. (Laughter) You know, there's no other system that would tolerate that.

MR. GALSTON: Well, on this delightfully disquieting note, I'd now like to turn it over to our patient audience. And just a word about the procedure from here until the end of the session.

Raise your hands, wait to be recognized. And then when I recognize you, wait until a roving microphone arrives so that everybody can hear what you have to say. Please identify yourself. If you have an institutional affiliation that you'd like to put

on the table as part of that identification, great. And then ask a short question and identify the person or persons to whom the question is addressed.

And with that, the floor is yours.

Okay, there is a woman in the aisle towards the back.

DR. KAUFMAN: I'm Dr. Carolyn Kaufman. Some of you know me pretty well. You've talked about cost in the system as though -- except for Dr. Reischauer, as though it were the same thing as price. And in a competitive market, price and cost are very close and there are competitive markets in medicine. Primary care is one. Generic injectibles is another, and there are shortages in both those areas because the competition is so stiff. But Steve Brill's article about a month ago in *Time* showed that there were huge profits in other areas. And if you're reducing volume, then what you're giving to providers is more money for fewer services. You could reduce cost by reducing price, and that's basically the approach they take in Europe, where they have a lot less expensive per capita health care with results as good or better than ours. What do you think of that?

MR. GALSTON: So whoever would like to respond to that is free to since it was not specifically --

MR. ANTOS: Well, so here's a start. I'm going to confine myself to Medicare. But, you know, the problem that Medicare has had all along is that it can't find out what the price is. Medicare fee-for-service attempts to micromanage the prices; there are literally tens of thousands of codes. And it's -- I would argue that it's impossible to get it right.

Now, the thing about price setting is -- and I am a former rate regulator, so I speak with some degree of experience on this -- the thing with price setting is that you only find out from those you pay if they think the price is too low. You never find

whether they think the price is too high, and that's why you need a competitive system.

DR. RANDALL: I'll go. So in our experience, and I think somebody referenced it earlier, you see when price comes down, volume goes up. So in my experience it's not so much about controlling the price, it's about completely changing that payment methodology altogether to align the incentives so that the payer, the health care professional, and the individual all have aligned incentives around their goal of care. So what I mean by that is if you have an individual who is approaching the end of life and their goal of care is to maintain their functional status, they want to remain independent as long as it's possible to do so, but if what they're getting is a significant amount of technology that causes them to be in a restrictive setting and not maintain their independent, that may be contrary to their goal and having that discussion so that goal is aligned to the member's goal, the patient's goal.

The second is around transparency. So I think that you mention it very nicely around the cost, so that everyone's really clear on what that total cost is, the consumer, the health care professional. It's very common for us to have discussions with the primary care physicians in our network who ordered medications that are on the formulary that had no idea how much that drug cost before they wrote the prescription and then their patient came back in and complained about the cost of it. So the transparency around that is really important.

And then last, the methodology and the payment mechanism, aligning it with the desired outcome, not just the process.

MR. CAPRETTA: With respect to comparisons internationally, obviously there's great diversity around the world in terms of their health systems, but Europe specifically, there's also great differences cross countries there. But there is one uniform rule, which is that in systems that rely on a price-setting system to keep their costs under

control, the effectiveness of the price-setting system is almost -- it was very predictable in basic economics that it's the supply control. Essentially it reduces the supply of very expensive care to some degree. That's sort of the way it works and that's the intent of the way it's supposed to work.

Now, by and large that's not a detrimental thing for primary care, which is relatively inexpensive, and the political system can supply that to a pretty good degree through direct subsidization, which most of these countries do, and it's convenient for a large portion of the population. The problem comes in with capital-intensive purchases and highly technical where you need a very trained personnel to perform some very rare but important procedures on patients. They tend to underinvest in that and, you know, that is also picked up in some of the data that compares internationally.

MR. REISCHAUER: Let me just say something.

MR. GALSTON: Please.

MR. REISCHAUER: You know, ideally, when you have prices, you would like those prices to be for outcomes and quality and not for inputs particularly. And, you know, both outcomes and quality are very difficult to measure, number one. And number two, there isn't a direct line between the inputs and the quality and the output. I mean, it might work for him, but it won't work for her, and it'll work somewhat for him. And so what you need to do is have sort of a large group and treat sort of average quality, average outcome versus price. And it's very hard to do when you have a lot of the delivery system in mom-and-pop kind of organizations as opposed to supermarkets. And, you know, this is a challenge and we're trying to, you know, move in that direction, but it's not going to be fast and it's not going to be easy.

MR. GALSTON: Well --

SPEAKER: I -- just a question.

MR. GALSTON: I'm sorry?

SPEAKER: Go ahead.

MR. GALSTON: Right. Well, actually, you know, I feel compelled just for a second to abandon my moderator's moderation and just to add to the question that's on the floor.

Last year, I read in the Kinsey study that compared salaries in the health care professional around the world, and one of the things that you notice is that salaries almost up and down in the U.S. medical profession are substantially higher than they are in Europe. And presumably, that is baked into the prices of all of these services being delivered. Query: How did that come about? And are we getting what we're paying for it?

MR. REISCHAUER: I mean, it came about, in part, because we have an unconstrained budget for health care services. And people who are demanding the services aren't aware of the price or the cost of this service. You know, when you go out and you buy a loaf of bread you know that if you buy the bread, you can't buy the pork chop because you don't have, you know, enough money to buy both. We buy health care through insurance that's provided, in large measure, for the under 65 population by employers. Employers pay for their share of that insurance through reductions in our wage income. Total compensation stays the same, but more of it is devoted to fringe benefits in health. And we go to the doctor and, for all practical purposes, it's close to free. We're paying the \$20 co-payment, we're not paying the \$98 full. And there are arguments for why it should be that way. But, at the same time, it creates little restraint on the part of the provider, so they can run up the prices.

Now, the insurer in the old days, maybe less so today, was really like the water company. You know, it took the money from the employer and sent it through its

pipes and it went out to the hospital or the doctor's office, and it's siphoned off a little. And the more water that went through the pipe, the more it could siphon off. So it really didn't care that much that the hospital costs were going up at a great rate. And the employer didn't want to tick off the employees by saying, well, you know, we've decided at this point that you have to go to Holy Cross Hospital, you can't go to Georgetown or George Washington or some of the other more expensive hospitals. You know, that's the situation we're in.

MR. JENNINGS: I just want to say that, you know, the whole question of this -- and it was a very good question. It spurred on a whole conversation and we could have a whole panel on it. But I do believe that, you know, look, cost is price and use and underlying how much you're paying for it, the price is the salaries embedded in that. There is no question we spend way too much money on health care relative to what we get back in return for it. So the question really is how do you squeeze out without undermining quality and access into health care?

I have a feeling in this country we'll always spend more than every other country. The question's going to be how much less can we spend while still getting a better return on the investment? And these new models are being constructed to try to squeeze out some of that.

There's no question that fee-for-service doesn't -- it's much better on the pricing, but it's terrible on the use. You know, that's just the -- the utilization incentives are significant under fee-for-service. So how can we find ways to focus on that as well? And, look, if we're always going to say it has to be fee-for-service or it has to be competition, I think we're going to lose out something in terms of how we can best get an enhanced health care delivery system.

And just, if I may, just say on this policy proposal that the difference

really on these Medicare networks is that they are provider-led. Under a capitated payment they will learn how to allocate their resources more efficiently to improve outcomes. It's going to be far more coordinated. It's going to be -- we're going to, for the first time, have two-sided risk. We're going to have shared savings, far better than what we're seeing in the current ACO models.

And so really, at the end of the day, if we don't find some amalgamation of the best of both systems, we're going to continue to space ~~[sic]XXXMAYBE HE MEANS "face"?XXX~~ what we do today, which is uncertain, unpredictable, and almost always higher health care cost. And no one can say that our current system is working. It's working now. I would say that we do have a temporary pause on health care cost, but health care cost growth in this country on a per capita basis, Medicare's doing better than everyone. There's no question about that. But it is true that no one is also saying -- I will say maybe 90 percent of the health economists in this country will say that it cannot be sustained in the absence of more delivery reform changes -- delivery and financing reform changes.

MR. GALSTON: Now back to our regularly scheduled program. The woman over there at the end of this aisle.

SPEAKER: Thank you. I am a licensed clinical psychotherapist. And I remember in a sociology class in undergraduate school at the University of Maryland one of my professors said in order to change one part of the system, you need to change another. So I would like to say the discussion today is reforming Medicare. And Mr. Reischauer, who has stated we need true reform, that means changing attitudes, behaviors, price structures, what have you, along with -- I do agree, and Mr. Capretta made comments and Mr. Antos.

I am on Medicare. It is not a great system. So my question I'm going to

put out to all of you. And UnitedHealthcare, you are AARP, you're one of the largest insurance companies. You're supplements to many of us who have to have a supplement to Medicare, which I don't understand, to Part B. And we do need to change attitudes. It's going to have to change. Not just for me, it's down the road, the younger people.

If you're talking about fee-for-service and I want to pick it, my doc, I like competition, but you haven't addressed the major part of health care reform, which is the patient-doctor relationship, the issue of deductibles and the amount that it's gone up, and the issue of possible malpractice if a patient knows enough says I don't want this test, But the doc has to cover themselves because if they don't, they're going to get sued. And that has never been part of this health care, Medicare, or Affordable Care Act discussion, and I think it's a very important thing. I've had to get malpractice insurance.

So where are we with this? Down the road, not today, not tomorrow, but for folks who in time will get onto Medicare, and it does need to change. Thank you.

MR. CAPRETTA: Well, there was a lot there. I think I'll address the medical liability portion of it and invite my panelists to help me.

I think you're right that medical liability needs to be reformed. It wasn't changed substantially in the health care law that passed in 2010. There is probably more of an opportunity now than there has been in the past, I think, in part, because the Congressional Budget Office says it'll save a little bit of money. So they changed, I don't know, maybe three, four years ago on that point. And so at some point along the way it wouldn't surprise me that the policy might get pushed along just by virtue of the fact that it could be used to pay for some things in the right political environment. Not to say that it will because the political coalition that's against it is quite powerful, but there seems to me there's more of a possibility now than there had been in the past, if that's of any



solace.

MR. ANTOS: Well, let me address a little bit the patient-doctor relationship or the patient-doctor-doctor relationship, which is maybe just as important or more important. One of the criticisms of traditional Medicare is that it is an uncoordinated system. That's correct. And the coordination isn't just between patient and doctor. There's obviously the fee-for-service incentives can get in the way of that, but it's also the failure of traditional Medicare to really provide structures and incentives that encourage the coordination across the continuum of care, doctor-to-doctor, doctor-to-hospital. It's a very, very difficult system.

Now, Medicare's not unique in this, but Medicare could take more of a leading role in trying to resolve that problem. It's a very difficult issue.

In the end, I think what we need is health plans, whether it's Medicare or other plans, that focus on this. And I think that's going to be driven by the inevitable pressures that we're seeing, the financial pressures that we're seeing in the medical sector, and the growing awareness of younger people that they can be served better. In fact, the Internet isn't such a bad thing. They find out things, sometimes it's right. But younger people, unlike my mother, younger people know that things could be better and are willing to speak up.

DR. RANDALL: And obviously we're dropping out of Medicare --

MR. GALSTON: We have time for one final question, and the women with her hand up right there.

SPEAKER: Hi. My question comes directly from my affiliation as a foreign national with the UK government, sort of along the lines of what we have in referencing in terms of other systems and with the recent reforms to the NHS being devolution to clinical commissioning groups. And we've mentioned -- Joseph, you said

how do you align incentives with physicians? And how do you put more power into their hands across the board? And so they've done that in the UK by devolving these systems to these groups. And I was wondering if any of you, particularly maybe Joseph, had ideas on how that would work in practice in the United States.

MR. ANTOS: Let me turn this over to Bob. (Laughter) So your issue was how to get physicians to feel that they're more in charge. Well, in some sense, they are in charge. They're certainly in charge when I visit my doctor. I think the question really, for me -- my answer's going to be a financial question -- that the financial relationships up the line cause, you know, some obscuring of what that relationship is. The doctor is really responding to two people: the patient and to the payer. And so, to some extent, I think the way to look at this, at least the way I look at it, is to work on the financial end of it. That's the end we can deal with. If you change the incentives, people will change the behavior, but it's really hard to directly change the behavior otherwise, I think.

MR. REISCHAUER: Well, ~~(inaudible)~~ the system directly it involves partial capitation to the health groups. And, you know, I think everybody here would sign on to that, but, you know, it worked better in California, where there's a lot of multi-specialty group practices and not so well in New Jersey, which still has, you know, Dr. Welby, you know, alive and well and dominating.

MR. JENNINGS: Right, and I would say that you look at some of these new provider networks as opposed to maybe a traditional MA or traditional fee-for-service where they are sharing in risk, then they are sharing in the responsibility of managing those costs better. And I think that that's an encouraging trend.

I agree with Bob that in different parts of the country it will move more quickly, but there's no doubt in this country that we're seeing huge consolidation of our

health care industry. And the physician community wants to be part of that and are moving particularly on the SGR reform, the physician payment reform that we're seeing before Congress today. They're opening up the door to anything other than the old way. We'll accept it if we don't have to do an annual figure over our SGR physician payments. And so that actually has been an encouraging development that may lead to reforms in that direction.

MR. GALSTON: Well, we have now come to the end of our session. And let me just say a couple of things in conclusion.

First of all, I have found this personally a very clarifying session. I think that there is agreement, and as far as I can tell it's a well-founded agreement, that the current fee-for-service system is defective in at least two respects: first of all, that it has put upward pressure on volume, which is not really very well compensated by the quality of outcomes, certainly not in proportion to that upward pressure; and secondly, it is helped to sustain beyond its useful lifetime a system of very individualized and uncoordinated care across different practices, different services, and that a system that creates incentives for greater integration would be a very good idea.

And so it seems to me that the question not just before the assembled company, but before the Congress and the country is if this system is not effective and is not sustainable, then with what should we replace it? And the fact that there is not total agreement on the answer to that question does not gainsay the fact that I think increasingly, as analysts and as a society, we're coming to agree on the definition of the problem. That, it seems to me, is more than half of the path to a solution. And so thanks to the panel for making that point so clear and driving it home from different perspectives, different disciplinary perspectives and different political perspectives.

Second and finally, please join me in thanking our panelists for a superb

hour and a half. (Applause)

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