

THE BROOKINGS INSTITUTION
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STRENGTHENING MEDICARE FOR 2030

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P R O C E E D I N G S

MS. RIVLIN: Good morning and welcome. We are very glad to have you here this morning to talk about strengthening Medicare for 2030. I'm Alice Rivlin, I'm the Leonard D. Schaeffer chair in health policy at the Brookings Institution and I direct the center for health policy here and my happy job is to welcome you on behalf of Brookings and the health policy center and the economic studies division and everybody else at Brookings. This meeting is a joint venture with the Schaeffer Center for health policy and economics way out in California at the University of Southern California. It is not our first joint conference, some of you were here last October when we had a joint conference, a very lively one on the cost and value of biomedical innovation which dealt with pricing and coverage of breakthrough drugs. But we have been planning this conference on the future of Medicare for quite a long time. My friend, Dana Goldman, who directs the Schaeffer Center at USC and who you'll hear from in a few minutes and I and Paul Ginsburg who has a foot in both camps, have been working together to plan this conference. Paul is the Norman Topping Chair at USC and – in which he was installed last night and also a nonresident fellow at the Brookings Institution. This conference will kick off a two year joint effort between the two institutions to work on how to modernize Medicare and meet the challenges of the next decades. And from which we hope to have interactions with policy makers and some policy action. Medicare as you all know celebrates its fiftieth birthday this year, it's been a hugely successful program over that period, it has changed the experience of being old in America, it has financed care for millions who would not otherwise have had it along with social security it has reduced poverty, anxiety about medical expenses and it's helped the elderly and the disabled to live longer, less painful and more productive lives. But we are not here to talk about what Medicare has accomplished. Others are doing that this year all over the country. We are

here to talk about its future and we chose to look at what the world will be like in 2030. 2030 used to seem like a long time in advance but it's only 15 years from now. But we chose it because it is a time in which the whole baby boom generation will be eligible for Medicare. We will start with focusing on 2030, what will it be like then, how many people, how healthy, how wealthy or not, what resources, et cetera, it's a mixed picture and we will turn to that in just a second and then we will go to what the policy options for the future might be, eligibility and benefits, payment reform, choice and competition. It is now my pleasure to introduce none other than Leonard Schaeffer to make a few remarks on behalf of the Schaeffer center at USC.

MR. SCHAEFFER: Thank you Alice and let me add my welcome to all of you for being here this morning. I will try to be very brief because we have some excellent panels, we want to get to them right away. I do want to say though how pleased I am that Brookings and the Schaeffer Center are working together on these important issues. However, I have to make two formal disclosures. Uh, the first is that I am on the board of Brookings and I established Dr. Rivlin's chair and I am also on the board of USC and I established Dr. Goldman's chair, second I was administrator of HIKVA now CMS many years ago and for the record I want to state that when I left HIKVA everything was in perfect shape. There are people here in the room that are witness to that – those are the good old days. Well actually that wasn't quite the case, when I joined HIKVA in 1978 we were all ready concerned about how to insure that Medicare was both well managed and that we were able to control costs. There was also a dawning realization that the ability to collect and integrate data – to analyze utilizations and costs would grow over time.

What we didn't anticipate was the resistance to turning that data into information that could be used to improve medical practice and inform better health policy

and we are still I think dealing with those kinds of issues. Now the description of a conference as Alice said – it says that and I quote, “instead of reflecting on historical accomplishments this event will look to 2030. I certainly agree with the forward looking agenda and its emphasis on modernizing Medicare. I’ve been concerned for quite some time are driving our accumulated deficit and that is having a negative impact, or potential for negative impacts on our economy and on our national security. This conference suggests that many of our best health policy and economic experts are focusing their work on solving these problems and that’s good news.

I was told a little bit different story about why 2030 was chosen as the focus for this conference. First it’s the date by which the youngest of the baby boomers will turn 65. It’s also the year that the Medicare trustees project that the Medicare Hospital Insurance Trust will become insolvent. However I’d like to add another and in my opinion a far more important issue and that is that I intend to be around in 2030 and using Medicare and I would appreciate it if you guys would fix it up so that it functions well then. Thank you very much. (Applause)

MR. GOLDMAN: Thank you both very much, it’s been a real honor and privilege to work with Alice on this project and in the other projects. My name is Dana Goldman, I am also the Leonard D. Schaeffer chair and director of the Schaeffer Center USC and what I want to do is talk a little bit about what 2030 looks like for Medicare, but in order to do that I first want to show you the share the Medicare is going to consume of GDP over the next 20 years and many of you are familiar with forecasts like these. This is a projection the CBO did in 2007 and Medicare as a percent of GDP is going from about three percent it’s more than doubling to six point five percent. Now you might say this is an old projection so let’s take a look at what the actual data show and actually we’re going along, CBO should be commended they did a very good job with their

forecast, so here's their 2014 projection. As you can see now they are projecting that Medicare spending will only consume 4.3 percent of GDP, this is 2035. And these may appear like small differences but there's about five trillion dollars in the gap between those two. And so the question becomes is there something wrong with the way CBO is doing their forecast and the answer is no. I think they've been quite successful as you saw from that earlier experience. The point is that there is a lot of uncertainty in various ways that are driving Medicare so we're going to talk today about the demographics that are driving the program and Leonard hinted at those, we'll talk about population health which obviously matters. We'll talk about health use and technology and then there are issues like benefit generosity so CBO part of the reason – their forecasts go off the – start to diverge because the program has either been expanded in terms of eligibility or maybe we added something like a prescription drug benefit or something like that and then finally reimbursement and payment policy matter. For this first panel that we are going to do this morning we are going to focus on the first three and then I think as the days go we'll hear more on the latter half of what's driving this and in some ways this is the most obvious part of what's going on. Here you see the racial and ethnic make-up of Medicare beneficiary population in 2010 and here's what it looks like in 2030.

The big difference of course is that the increase in the Hispanic population that we're going to see. Now you might ask why does that matter? Well it turns out Hispanics have larger families. It may mean that more capability of a family to assist elderly people, maybe it means something for long term care, I don't think we've fully thought through the expansion of the Hispanic population through these projections. The other issue that we're grappling with is the change in education, so in 2010 in the Medicare population 21 percent of the population had less than a high school degree. That's going to shrink and in fact you'll see that 62 percent – a majority will have had

some college and we know that education is tied with health in ways that I think will be discussed later. And so the bottom line also is that the distribution within the elderly population will change. This is what the population pyramid looks like for people age 65 and older. There will be 40 million beneficiaries – there were 40 million Americans age 65 and older which is close to part A enrollment because it's nearly universal. Here's what that population pyramid looks like, uh, but the bottom line it's the number of beneficiaries is going to increase by 27 million. We're going to see more Hispanic representation, we'll see the population better educated, we're going to also extend the right tail of the distribution so right now for example the number of people over age 100 is relatively small and it's always – usually there is some sort of party when someone gets there, but we're going to see relatively large growth in the centenarian population and so you might think that the average age of the population will rise but actually because of the incoming cohorts from the baby boom the average age will not change but the point is they will be dispersion. And so I think that kind of summarizes the key demographic changes, but let's look a little bit about the underlying population health because we're all worried about that.

And one of the areas we have the most concern about and people are talking about is the distribution of obesity, if you look in 2010 about 28 percent of the population was obese depending on you can see the differences by class of obesity, but that's going to rise to 47 percent and the real concern by the way is not the overweight so much because actually a lot of the diseases in older populations are associated with wasting. And so being overweight can actually be protective at older ages, but this severely or morbidly obese, that category is growing quite rapidly. And there's also good news, we see less smoking so if you look at the fraction that are current smokers, it's going to decline from 11 percent to eight percent and the fraction who've ever smoked from 57 to 48 percent,

so we know that will have effects on the population and so we can forecast – what the prevalence of chronic disease looks like and you would expect that there'd be more disease in 2030 and you see it. We see a lot of hypertension but especially the increase in diabetes. Fifteen percentage point increase in diabetes. The other point though is not just single disease but the prevalence of multiple conditions and so we're predicting that 40 percent of the population will have three or more chronic diseases.

And this puts a challenge on the model that we have and I'll come back to this later which is a single disease model. Let's go to this doctor to treat my diabetes, let's go to this doctor for my lung disease, the seeing of specialists and so the question becomes can we use geriatric care, can we provide comprehensive services that will address the constellation of illnesses we're going to see in the older population and I think that poses a challenge on the supply side. But the net effects here really can be shown if we look at life expectancy. The way to read this graph is it shows life expectancy at age 65 for someone who is 65 in 2010 and they can expect to live 17.7 more years. But we also worry about the quality of that life and so what we've shown here is the number of years that are spent in a disabled and non-disabled state so we called 11.4 of those years they're healthy and 6.3 they are disabled. Now the goal for public policy isn't just to increase longevity or the goal for our health care spending for that matter. The goal would be to increase the red and shrink the black so to speak. And what you see though is the projections don't look so promising. You are increasing life expectancy for men and by about a half year or more but most of that there is going to be a lot more disability. And if you look at women you see a similar trend, an expansion of the amount of time they'll be spending in a disabled state so these again are raising warning flags. I also want to talk a little bit, this will come up in a minute as well about the equity of the gains we're going to see in population health. We worry a lot

now about income inequality and wealth inequality, but it's interesting to think about health inequality as well and without going into too much detail, one thing you can do is ask which part of the income distribution is going to gain the most over these twenty years in terms of life expectancy. What you see here is the data for men who are poor in the lowest income quartile, so the low is 25 percent. They are going to gain just under two years of life expectancy over this period.

But you look at the highest income quartile they are going to gain about four and this gap in life expectancy which is kind of like an earnings gap is about 2.4 years. For women the gap is similar, it's about 1.8 years. If you think to some of the basic statistics here which is if you look from birth at a black American who has not finished high school versus a white American who is college educated they have about a 14 year difference life expectancy. That's about the difference between say Estonia and the United States. And so if you think about the fact that we are going to be exacerbating that potentially it puts a lot of tension in the social fabric. And so it's something I'll come back to at the end as well. The summary for the health changes though, we are going to smoke less but we're heavier, there will be more chronic conditions and we will be living longer but spending more time with disability.

Now I want to talk about health care use and medical technology and one way to summarize health care use is just look and we're interested in Medicare spending obviously is to look at the net present value of how much Medicare is contributing to healthcare use for someone who is age 65 in 2010 and that lifetime benefit so to speak is about 131,000 in net present value terms. In 2030 it's going to go up to 223,000. Okay, so we are going to be spending a lot more on each beneficiary over their lifetime and this in part reflects not only that life expectancy gain but also that increase in disability. And again I want to point out the disparity so you might say who's getting that

increase and I think here is where policy – we need to be careful because it turns out that most of those additional benefits are going to high income people and it comes back to what I said about life expectancy. They are getting older and you are paying more over time. And so the question about the progressivity of the program is going to come up.

Finally I want to talk a little bit about medical technology, you all know that medical technology is a driver of healthcare spending, but I want to talk about what it does to these trends and sources of uncertainty. So here you see that we're unlocking the secrets of longevity jeans and some of you may be familiar with the biomedical evidence here so it turns out one of the most overwhelming relationships in biomedicine is that if you take an animal and you can use whatever animal model you like, and you reduce their caloric intake by about 40 percent you can actually increase their life expectancy by 60 percent and there is no drug that does that right now. But it turns out they found some drugs like rapamycin where they can imitate that behavior. The problem is if you give the rats just a little too much they die. It's not quite ready for prime time yet, but the private sector is starting to explore this, so this is Larry Page and Art Levinson. Art Levinson is the CEO of Genentech, Larry Page was the founder of Google and they have a company now that is looking at anti-aging Cali. Co, so you know that there is at least some potential here so this is not the pie in the sky that we used to think about. We actually looked at what it would do to Medicare population if we realized some of the promising in the biomedicine.

And we compared it with these disease model, that is for a long time and currently, mainly our R&D is about we're going to cure heart disease, we're going to cure cancer, it hasn't been we are going to unlock the secrets of aging, so if you look at the nondisabled population, 65 and older here is our baseline scenario and here's what it's like if we were to delay cancer, that is we'd reduce the incidence of cancer by 10 percent

which is a big deal, okay and here is what it is if we'd do that in a similar effect in cardiovascular disease. But here's what it looks like if we do what the animal models are telling us with delayed aging, what you see there it's kind of summarized in a table on the right, but, you know, we could be seeing an increase in population size of 12 million above what anyone has forecasted. Now it's funny because when I come to Washington there's a ton of hand ringing about this graph, but in California everyone is excited. I don't know if it's because you get a lot more years in the sun or what but the bottom line here is this is potentially a boon to society, but as I said figuring out what to do about this technology is not easy. So for example supposed Calico is successful and they come up with a pill that you actually take when you are healthy and it keeps you healthy. Is that covered by Medicare? I mean, you know, Medicare doesn't typically cover supplements.

Usually we wait until you are sick in order to give you a pill and cover it and suppose it's not covered by a pill then? Or sorry – suppose it's not covered by Medicare. What does that mean for these gaps in life expectancy that I was talking about before because you can bet that Larry Page is not going to give it away free the way he does search engines so the point is that here's what that would do to Medicare spending, I'm just going to point out that Medicare and Medicaid and I'm just going to say that it could increase Medicare and Medicaid's spending by something like 250 billion a year of that is fulfilled so the point is that there is an enormous amount of risk. Let me conclude by saying that Medicare costs are going up due to a combination of factors, demographics, disease, functional status, medical technology. It's generally easy to forecast the baby boom population, it's a little more uncertain to forecast what the health trends are – they are affected by behavior and other things and this is the most risky part and we need to be able to come to grips with how we deal with all of these things as we go forward.

And the other point is that absent reform benefits are going to SKU towards those in the upper end of the socioeconomic and income distribution. Thank you. (Applause) It turns out that our next speaker Gary Burtless is sick so I get to fulfill a long held dream of mine and serve as a senior fellow at the Brookings Institution and I'm going to present Gary's slides and I won't do as good a job as you can imagine and I'll be much briefer. Which maybe that's a good thing and then we'll finish the panel. But it follows nicely on what I was talking about. I talked to you about the potential for health to – health inequalities and Gary's work for a long time has been concern with income inequality and in particular what we can do to help people who are at the left tail of the income distribution, that is the poorer individuals. And so what you see here is a very nice historical slide that shows the percent of Americans who are living below the poverty line by different age groups over a long period of time and so in 1959 almost more than one third of people age 65 or more were living below the poverty line and what you can see is the dramatic decline in elderly poverty that occurred in the late 60's and of course has continued today and obviously that's Medicare, Medicaid and Social Security. They've been and it shows the dramatic effects of this program in terms of protecting those who are the most vulnerable elderly. And you can see that we haven't done as good a job so to speak with people aged 18 to 64.

Those that are in the blue, we've had some protections in the 60's but that's tended to be flat and in fact may be on the rise a little bit and so another way to say this is to show how real income has changed over these periods for different groups so I'd present this from the bottom. The fiftieth percentile what it shows here is people in the median – people at the median income and what it shows are the income gains by age of household. And I hope I'm getting this right, but if you look – so the 47 to 49 category is a household led by someone whose 47 to 49 and the 80 plus is a household led by

someone 80 plus. And what it shows for the median groups within those age groups how much has income improved? So if I said the median elderly led household, think of it as the older American, their income is improved 47 percent over this period. Whereas the median household led by a 47 to 49 year old, their income is only improved 9 percent.

You can also ask – let's say what has happened to the poor in those groups, so if you look at the older household, older led households their incomes have improved since 1979, but the households led by younger people, their incomes have fallen, so the point is that this is getting more dispersed for the nonagent, whereas the agent we're kind of compressing. We're doing better for the bottom in the group and you can see here also what happens at the 90th percentile and you can see that the 90th percentile has improved over time and it's relatively uniform.

The bottom line is the younger richer households have done well and the older richer households have all done well, but the poor, poor younger households have not done well. This is shown here where you just look at the ratio of the income of the old to the young and this is what it looked like in 1979 and so what this means is that here at this 40th percentile and older household tended to have only 67 percent of the income of a younger household and so what you've seen though over time is that this ratio has gone up especially at the lower end of the distribution poor elderly are doing much better than the poor nonelderly were over this period.

And of course by 2012 we see that the elderly tend to be making more at every point in the distribution which is a rather remarkable phenomenon. And we see that, also what this graph shows is also the sense that how much of this earnings for these households is coming from work. At the 100 line what that means is that, um, the household, the average earnings of an older household are much higher, are coming from work rather than some other source of income. And in fact what we see is of course

it shows that at older ages earnings are less important for elderly income than other sources.

Another way of saying this is that when you get older it's really annuities and capital income and all these other sources of savings that matter for your relative position in society and the point is that the safety net, social security, and private earnings need to be sufficient to maintain this and if we're talking about as I said ways to deal with these increased Medicare costs by cutting the generosity then the net effect of that may be to reduce these gains we've made in dealing, in tackling elderly poverty.

I think with that, that's the best I can do for Gary, I apologize. I'd like to introduce the panelists and we'll have a wide ranging discussion. So I'd like to invite Greg Daniel, Julian Harris and Paul Van de Water up to the stage and we'll get them micc'ed up and while we're doing that you can read their immensely impressive bios in the packet that you have. Greg would you like to start?

MR. DANIEL: Thanks, Dana. Welcome everybody. I'd like to pick up where Dana left off in his presentation. It was a great analysis. It's great to have some quantitative data backing to actually look at what the Medicare population and composition might look like in about 15 years. One of the big significant findings that Dana showed is that we do see an increase in prevalence of chronic conditions, an increase in life expectancy and an increase in spending. In terms of biotechnology and more specifically drugs, that's what I tend to focus on here at Brookings that represents two things, one is a big concern what will the drug utilization look like in this population, but also it's a big opportunity. We want to have policies and an environment in place where we're encouraging breakthrough game changing technologies that hold promise for really improving health outcomes and potentially reducing costs on the medical side so for example in Dana's modeling of a potential new drug that can delay aging. I

suspect that would be a pretty expensive drug.

I don't think we've figured out how we would pay for it, but I suggest it will be more expensive than any other drug that we have on the market. And that's fine, maybe it should be. What we really should focus on is let's make sure that if we do have that drug on the market who is the right patient to be taking that drug, what is the best way to take that drug and how do we make sure that we're maximizing the opportunities of that individual drug to actually show us the benefits and actually potentially reduce spending on the medical side although your modeling suggests all increasing spending.

That raises the question of cost containment as well, between now and 15 years I think we are likely to see more of the disease model approach. If you look at the pipeline of drugs in the pipeline today generally it takes about 10 years or more to get a drug to market so you can look at the pipeline now and pretty much predict what the drug utilization or drugs available on the market will be in about 15 years and we're seeing the trend actually going towards more targeted, more specialty breakthrough therapies for rare disease and smaller subsets of disease.

For example, we've seen just in the last year a lot of new drugs, very expensive drugs for hepatitis C, very specific new drugs, targeted drugs for cancer, we're expecting to see many more drugs to treat rare disease. Just as an example the number of drugs on the market for rare disease doubled in the last five years. There's about 450 drugs for rare diseases in the pipeline today so we will continue to see more targeted more specialty disease focused drugs, that are coming at very prices. So that brings me to I think some of the topics that we'll cover in later panels, but I think it's particularly important for bio-technology and let' figure out a way to make sure that we're making the best uses of those technologies. Leonard Schaeffer mentioned in the beginning in his opening comments of the real importance of turning data into information. That's a

critical component. We generate so much data as we use the health care system today from claims data to electronic clinical data in the medical records. Patient reported data through surveys and through other instruments that physicians might give, but we don't use that data very well at all, but we need to start doing that. Drugs that go through the clinical development process answer important questions about can this drug work in a perfect scenario. That's what clinical trials do. But when a drug gets on the market we don't really know how they'll actually perform in the real world setting when drugs are used in patients with multiple chronic conditions or they don't take the dose or physicians may not use the same dosing that was used in clinical trials or patients are not adherent. All of these things we can learn from that, we can actually utilize the data that are generated as part of those routine visits to look at we have these new technologies on the market what are the most valuable, most cost effective uses of those drugs? Identify the patient populations that most respond. Make sure we are targeting those drugs to those populations and make sure we have programs in place to increase adherence. The last part that I'd like to comment on and this is really about the Medicare benefit structure which is quite fragmented when it comes to drugs. If I were to add to a research agenda it would be let's take a serious look at how drugs are treated with the current Medicare benefit structure and look at scenarios that might get to better lining incentives to maximize the opportunity of those drugs to increase outcomes and potentially reduce spending on the medical side.

I think Henry Aaron has a paper we've suggested bringing Medicare parts A, B and D under the same plan. That's a great idea because right now part D which is the drug benefit is completely separate often by a completely different plan. In that case there is really no incentive to use more expensive drugs on the D side if they're actually going to result in lower spending on the A and B side, the medical side, so drugs

that might prevent ER visits might be expensive on the D side but could reduce spending on the A and B side. Another potential problem with the current structure is Medicare Part B actually covers drugs too.

Drugs that are used in physician office settings so chemotherapy, infusions, those drugs are treated very differently in the payment policies for those drugs are very different than traditional drugs that are used in the outpatient setting. So one might look at that and say physicians are reimbursed, there's a scenario buy and bill where physicians will actually buy the drugs that they are going to use in their office like chemotherapy and sell them to the patients in the form of utilizing them and then getting reimbursed from the health plan. The reimbursement ASP plus six percent but really what it does is it tends to incentivize the use of more expensive drugs because the reimbursement is higher. And physicians are in the business of buying and selling drugs and they don't really want to do that I suspect. One potential reform would be to take all of the part B drugs and move them over into part D. Part D uses health plans that generally do a pretty good job of negotiating prices containing cost through utilization parameters like tiering, like formularies. I'm not sure if that's the best answer but we should look at that. And then finally for drugs that are on part D we don't have a lot of opportunities to pay for performance to really align the reimbursement of those drugs to better outcomes, rather we just sort of reimburse in a fee for service model which is reimbursing the price of the drug but not really tying that to outcome.

I think that's a very important aspect to look at as we move from now to the Medicare program in 15 years.

MR. GOLDMAN: Great, thank you, Greg, appreciate all those specific options to strengthen Medicare. I should say you mentioned the drug would be very expensive. There is a drug actually right now that will improve outcomes in all diseases

and increase longevity and it's relatively inexpensive and it's called exercise, Julian?

MR. HARRIS: Thanks, this is my first sort of outing since leaving the White House three weeks ago as the associate health director for OMB, so wearing my civilian hat.

MR. GOLDMAN: You can go wild.

MR. HARRIS: I can tell you what I really think we should do in Medicare. I should also give one other bias which is that I'm a former Medicaid director and that will color some of the things that you'll hear me talk about today. Certainly from both of those perspectives a lot of concern about that 1.2 trillion dollar number even though we've seen that a percentage of GDP has gone from being 6.5 to 4.3 percent and the significant savings that that will mean over time. Very concerned about sort of the long term landscape and it was interesting that Leonard highlighted the overlap of the 2030 with the exhaustion of the trust fund that actually was a four year extension of the exhaustion date from the prior trustee's report and so we'll see next month what things look like on that front, but there's no question that the spending remains a concern from the fiscal perspective. I want to talk about a few other areas that I think merit some additional attention.

One is long term care and this came up briefly in some of the other comments but as we think about the future of Medicare going forward and we think about a relationship between Medicare and Medicaid over time I think that there is an open question about whether or not as we think of that new structural purchase in Medicare some of the things that will be discussed later in the day from combining part A and B to thinking about support models or unified Medicare models whether or not at some point Medicare will play a different role.

There are different perspectives on that, but I think it will be an important

question as we think about the program going forward. I think it's also important to think about this population of folks who have both Medicare and Medicaid but to an eligible population. When I was Medicare Director of Massachusetts we stood at the first of the duals demonstration with CMS.

But I think that there are a lot of questions over time as we think about both in general having and increasing prevalence in the disability elderly population and the more broadly speaking – the under 65 duals continuing to drive a significant amount of Medicare spending. What does the future of the program look like in that context. There are some, I think, interesting interplay in our conversations later in the day about the future of Medicare advantage and the nexus of that with the future of our payment/deliverer form models which we spend a lot of time working with CMS on at A and B, so whether accountable care models or buckled payments, I think over time we'll have to ask ourselves and answer whether or not one or other of those models does a better job of taking care of the most complex patients. We saw that the number of individuals who have three or more chronic conditions will be 40 percent. We layer that with the increasing frequency of a disability and we have to ask are there things that are unique about an integrated delivery system in its approach versus a health plan.

Are there different kinds of partnerships between managed care, Medicare Advantage plans and integrated delivery systems over time that will enable them to take new and different approaches and how do those two factors enter play.

I think there are also some interesting things to think about in the context of technology and Greg touched on a number of these so if we get this magic pill and that scary curve that Dana showed us, if we get this magic pill how much will that increase our appetite for adjusting the Medicare eligibility age? Certainly you raise some important concerns about doing that in the context of these very significant gaps and life

expectancy both based on income but also based on ethnicity. In the short term I think that those have informed some conversations among other factors about adjustments to eligibility age but if we are having that dramatic increase over time how does that impact people's thoughts about how that might be adjusted going forward.

It was also interesting how in Gary's slide, when you showed the curve, the downward trend of or the increasing, sort of the decreasing percentage of people's income, one of the things that was interesting 1985 versus in the 2000's was the actual Medicare beneficiaries are actually – today's Medicare beneficiaries are actually having high levels of income compared to some of those in the past and so it will be interesting to see if we actually get those kinds of gains in life expectancy what will that mean for GDP and some of the other things that will impact that way that we think about healthcare spending more broadly.

Very interesting the descriptions of the young elderly and then the second half of the baby boomer population. I spent a lot of time thinking about the nexus of that with technology like this iPad that I have here, so the iPhone came out in 2007, so most of the people who were in – many of the people who were in the first half of the baby boomer generation will have grown up with different types of technology, how will that enable them to participate in different kinds of ways whether it's being able to take greater accountability for cost over time, being able to hold the providers accountable and their plans accountable in different ways for quality or maybe even tools that will enable them to do things like participate in exercise programs more vigorously and so it will be interesting to watch that trend over time.

And then the last thing that I'll end with, there were some interesting in the paper about the decreasing (inaudible) and I will just plant a seed. People in this audience paid attention but I think a lot of folks in the press didn't notice, but one of the

major pay fors in MACRA and the SGR bill was a modified version of the proposal in the President's budget to increase the contribution to the part being deemed premium for the Medicare beneficiaries and in my mind for a lot of the conversations that will happen later in the day about the potential for a range of structural reforms. The fact that even in what is a very contentious time and space in health care in Washington that such a reform was able to be achieved in a bipartisan fashion and relatively painlessly I think it actually provides some hope that it won't take until 2030 for us to decide to address some of the challenges that we've outlined in the paper today.

MR. GOLDMAN: All right, thank you very much. And very provocative, we'll get to it in the group discussion. Paul?

MR. VAN DE WATER: Thanks. I was asked to respond primarily to Gary's paper which is what the focus of my remarks will be, but given the rearrangement of the panel. I will be able to throw in a few comments about some of the things that Dana said which also did complement very well some of Gary's points. In Gary's prepared remarks which you haven't seen, Gary actually refers to his depiction of the economic status of the elderly as being cheery. Now I don't view myself as dour person and I'm not trying to disagree with Gary's paper, but I do think it's important to add a few caveat sources, a few words of caution to what might otherwise seem like this cheery picture.

One of the things that Gary doesn't talk about is how out of pocket medical expenses affect that economic well-being of the elderly. And it's interesting that despite the existence of Medicare and all the great things that it does, none the less the elderly still spend roughly three times as much as a share of their income on out of pocket medical expenses as do non-Medicare households. Roughly 15 percent of income were Medicare households versus five percent for non-Medicare households. There is another measure of poverty which takes that into account.

The chart that Dana displayed from Gary's paper uses the official poverty measure which basically focuses just on cash income but many, perhaps all of you are aware of the supplemental poverty measure which looks at a broader measure of income and also makes various adjustments to measures of resources and poverty thresholds. And one of the major differences in the supplemental measure is that it does subtract out of pocket medical expenses. If you were to graph that and I didn't bring a slide with me, but I can imagine it, you see the same drop off in the 60's and 70's in the poverty rate among the elderly and then essentially a flat rate thereafter.

The most striking difference is that instead of having the elderly poverty rate be substantially less than the rate amongst children and working age adults, the supplemental poverty measure shows poverty rates that are much, much closer for the elderly and the nonelderly, the difference between the elderly and those of working age is only about 1 percentage point and the difference between the elderly and children is only about two percentage points. I think that's an important qualification to add. Now I was going to talk about another topic which Gary didn't mention which is inequalities in measures of well-being that go beyond measure of income. But Dana did add quite a bit on that in his presentation. I'd like to say a few more words on that.

Dana talked about inequalities in life expectancy. Some of the earliest research on that was done by Hillary Walgren at the social security administration. A lot of others since Hillary's initial paper have continued to work in that area including Gary himself in a paper that he cites in the references in his paper. And that inequality in life expectancy shows up in a whole lot of different ways whether you look at inequality by earnings level, inequality by educational attainment, or in other ways. But you also see inequality in other measures. One of the other areas in which I've been focusing recently is social security disability insurance and there happens to be a huge disparity also in

disability incidents. If you look at people who are just approaching eligibility for Medicare, those in ages 60 to 64 the incidence of disability among college graduates is twice that for those with advance degrees. You then go to another notch to those with merely a high school diploma, their incidence in turn is twice that of college graduates and those with the least education, those who didn't complete high school have a disability incidence rate which is twice that of those who did complete high school. That's still another area in which we see these disparities. I recently saw – they (inaudible) a new paper by David Weiss and others which looks at disparities in health status and that too is – does show significant differences by income level. Now one of the big questions of course is what's going to happen going forward. Dana presented some projections. He didn't get a chance to tell us about the model which he used to do those projections. I thought it was particularly interesting to look at those projections about the number of years of life expectancy that will be spent in a disabled versus nondisabled state without knowing about the details of model (inaudible).

I would guess that those projections are related to his assessments about growth and obesity and the other chronic conditions which he showed in another slide. That may be correct. We don't know this issue, we've been discussing it for a long time as we've looked forward to an increase in longevity there's been an increasing discussion about how much of that increase is going to be good years versus bad years. My understanding perhaps not correct is that there actually has been a substantial increase in good years in recent history. We'll see what happens going forward. I want to echo a remark that Julian made about the importance of looking at long term care needs. That's obviously – there are serious implications for that. Financing of long term care remains a major issue, we don't have a very good long term care financing system in this country. Financing long term care through additional saving doesn't really make a

lot of sense since you're likely to have – to err in one way or another, for people to end up not needing long term care, they may end up saving or not spending much more than it would be necessary for those who do end up needing long term care may end up running short. That's another area which indeed needs attention.

Bottom line I think Gary's presentation is very useful and certainly Dana has complemented it very well, but I just wanted to add a few words of clarification and caution.

MR. GOLDMAN: We're going to do questions in a minute but I do want to ask a provocative question. I don't want to take the thunder from future panels but one of the issues that's coming out of your remarks Paul is that the outlook for the elderly is not as cheerful as we thought. In addition we know that there are these longevity risks. I mean if people live longer they outlive their savings and such and so the financial resources are potentially at risk. The question becomes – so that's on the financial side – on the Medicare side it's always traditionally been a very generous program. We saw the level of dollars that are going into it. Is there an opportunity to say hey we're not going to cover everything, but we'll give you the cash so thinking about the \$220,000 in lifetime spending suppose someone came along and said you know what we'll give you \$75,000 of that and then we'll give you a less generous policy. We'd be willing to accept people buying less than Medicare now offers in return for some protection on the financial side. Anyone?

MR. DANIEL: I would say that that follows the theory of insurance where you want to protect against catastrophic costs but you don't want to pay so much for your insurance that everything is covered. For example, with car insurance your policy would be really expensive if it covered every single little thing on your car so often times people opt for a policy that has a high deductible or something that they'll be willing to pay for

those things as long as they have coverage when something really bad happens and the car needs to be replaced. I'd say that I think some would go along with that but the majority of our society in terms of health insurance has opted more for desiring everything to be covered and then not so happy with the resulting premium, but hoping that something would take care of that.

MR. GOLDMAN: Julian are we willing to get rid of the universality of the benefit, not the eligibility, that is to say would we say that some people, let's say the poor or elderly wouldn't get a great coverage but they would get more income support. Are we ready for a reform like that?

MR. HARRIS: I might think of it in a different way. I think your slide in your data point about the decreasing progressivity of Medicare sort of highlights and some of the other data points around differential benefits, already they exist based on income. I think highlights the concern if they came out sort of with a single brush, there is no question, if your "scary graph" here in D.C. but not scary in California. If that came to pass I think that it would sort of change the game. There are a whole range of questions that are currently even more difficult to talk about that I think would become a bit easier to explore. I would caution – I think it's important to note the impact and I'd love to have a copy of that slide, but the impact of taking into account people's existing healthcare spending and looking at the impact on poverty trends over time before sort of making that kind of decision broad brush. I think it's also important to remember that even the current Medicare benefit some might argue has some pretty gaps, pretty big gaps compared to other forms of insurance both public and private that we recognize today and I know that will be a part of the discussion later in the day. I do think that the openness to consider a range of options will evolve over time both as we get closer to a trust fund exhaustion one day, but also as some of these other demographic changes continue to

sort of aggregate over time.

MR. GOLDMAN: Paul any comments?

MR. VAN DE WATER: Well your suggestion is an interesting one and I'm not going to give it a yes or no answer off the top of my head, but I guess I have just two reactions. One – we know at least that a lot of people, not only elderly but nonelderly have very, very limited assets. There is a survey that came out just recently. I can't remember the organization I'm sure, someone here does, that indicated that for a lot of people in our country facing an unexpected medical bill of \$400 would be a huge financial setback. Now for most of us on this panel and perhaps in this room that's probably not the case. We can think with meeting a larger deductible on our car insurance, it seems to be an eminently reasonable thing to do for the sake of getting lower premiums, but lower income people might react quite differently to that. There is a long standing proposal to income relate cost sharing and Medicare. I think that has a lot of conceptual attractions. But I think we have to be – our recent experience with the affordable care act and a whole lot of other recent experiences needs us to want to be a little more careful in extending the application of income testing. Income testing on a current basis turns out to be a lot harder to do than it might seem in the abstract so I think that would pose a lot of practical problems, but again conceptually it makes some sense.

MR. VAN DE WATER: Thank you, yeah, and I think I'm going to modify my proposal a bit now and say that you can take the cash, we'll give it not in cash, but we'll give it to you in Apple stock.

MR. GOLDMAN: Maybe that will make it more attractive, okay we're going to open this up to audience questions. I think – is there a microphone that goes around.

If not then I'm going to ask that people stand up, state your name, please avoid

soliloquies and I'm going to ask if you have two questions that you would like to ask choose the one you think is most salient and ask just that one and then the panelists will respond, yes.

MS. POPLIN: I'm Dr. Caroline Poplin, a primary care physician, also an attorney, I work on Medicare and Medicaid fraud in that capacity. You've talked about costs, not a single one of you has mentioned price. I guess you assume they're the same and in a perfectly competitive market they would be, but another way to reduce cost is by pushing for lower prices on some very overpriced things including pharmaceuticals.

MR. GOLDMAN: Greg, did you want to respond to that?

MR. DANIEL: That's a great point and certainly the pricing of pharmaceuticals does – we need to take a serious look at that. I don't think that there's evidence. We always here that it costs so much to develop the drug and that's a price and I'm not quite sure that the constant development is actually necessarily being used to set the price in most cases.

That is an important issue, but I would still argue that an even more important issue is making sure that we're looking at the total cost of care and not just sort of the technology sector because paying more for drugs that really do work could have downstream improvements and outcomes and total spending.

I think that we should look at price but not at the expensive of inhibiting innovation. It's risky too to develop a drug and to be not sure if A) it's going to be approved by FDA and if it is even if it's going to be covered and utilized once it's on the market, so those are important aspects that we need to consider if we are thinking about price caps because there could be an unintended consequence of not incentivizing the right kind of innovation.

MR. GOLDMAN: Let me add to that because I think that goes part way, but I want to point out that the price we're talking about is the wrong price and that's in the following sense. When I'm thinking about buying an iPad I go to the store and I see how much it costs and I know how much welfare gives me and so I decide do I want to get this or not. When we think about healthcare I really don't care about the price of the pill or the price of going to the doctor in the sense that that's not the good I'm worried about. I'm there because I want to get health, so what I really care about is the price of health. Now granted it's nice to go to the doctor's office and read the magazines from 10 years ago, but that's not why you are there, you are there for health and so the problem is that – and let me tell you why we get policy wrong because we look at the price of the inputs not the outputs.

When HIV drugs came along, highly active anti-retroviral therapy everyone was really concerned because they increased the cost of treating HIV and so there was a push to restrict access in some programs. Meanwhile it turns out these were some of the most efficacious drugs we've had in history and if you look at the value they created to society, it's about 1.5 trillion dollars in the United States and the revenues were about 60 billion so as an economist I say those were an incredibly good deal in health care, but at the time there were protests in the high price of those drugs. Paradoxically by the way now it costs a dollar a day to treat HIV in Africa. And so we're finally making global progress. The point is that the signals we're getting from the prices, because we measured the inputs are wrong so for example the price of an ICU stay is a lot higher than most of these drugs. And if you look at the health improvements it's not very clear how much health we get from intense treatment there. But because we don't pay out of pocket we intend not to see stories about the high cost of an ICU and yet, but if we thought about it how much health are we getting and how much are we paying for it.

We might come to different allocations and decisions.

SPEAKER: In terms of out of pocket costs that weren't covered by Medicare and how that fits into the elderly, generally Medicare doesn't cover things related to hearing, like hearing aids, it doesn't cover dental for the most part, it has very limited coverage of feet issues. My point is that as one ages there are certain critical functions that are generally not covered by Medicare and fall into out of pocket and dental can be quite expensive and yet the consequences for overall health are potentially quite significant because it gets into the disability issues and the functionality issues, cognitive issues. So perhaps we'll be getting into it later in the program? Otherwise how do you look at the fact that out of pocket sensory sort of things really hit the elderly harder than 45 year olds or 20 year olds and in the poverty line they are less able to pay them out. Like a hearing aid, you could all pay for a hearing aid.

Thank you.

MR. VAN DE WATER: I agree with what you say and that was the reason that I pointed out looking at the supplemental poverty measure which does take these out of pocket expenditures into account and one of the reasons why the elderly do have a high – you do spend a higher fraction of their income and out of pocket expenses which includes by the way not just premiums for Medicare, Medigap whatever but also the hearing aids and the dental car and so forth that you mentioned. There are obviously a whole lot of issues, there's no one or wrong way to look at things but I agree with your point entirely.

MR. GOLDMAN: I will just add that by the way I was just talking about the price of health, it turns out if you look across all the array of health care services probably the most effective things we can do is fill cavities because it reduces pain quite a bit and it doesn't cost very much. So, anyway, certainly.

MR. HARRIS: Two quick points, maybe not paying for the dental care, but probably paying when someone goes to the emergency room for pain to your point. I think on the dental piece it will be interesting over time as we're collecting additional evidence about the impact of oral health on other things like cardiovascular health whether people are making a business case that there should be some sort of coverage there. On the hearing side the cost of some of those technologies is coming down and so one might argue because the cost is coming down will that make it more likely that it will be covered or less likely that it's needed but it's certainly a positive trend. It certainly is an important source of morbidity for folks along a number of dimensions including impact on things like depression.

MR. GOLDMAN: It does raise a broader point for the panelists which is we talked about prevention of disease and generally we're in a model where you get sick and you get treated. We have this constellation of problems and one of the things one doctor said to me is I've got this patient he's obese, he's got elevated blood pressure, he's borderline hyper-lipodemic, the best thing I could do for this guy is take him for a walk, but I'm not paid to do that. And so the question becomes why doesn't Medicare pay for – should Medicare be paying for the preventive services that would maintain people in good health and that would have benefits and I don't want to argue that it's going to reduce cost, that's an easy one, if it reduced downstream costs of course it should cover it. But suppose it costs a little bit, but it gives people health that becomes a more complicated question.

SPEAKER: This always surprises people but costs are actually not taken into consideration for Medicare coverage determinations in a way that you might expect. I think one of the things will be interesting to watch over time. Let's just take your example of dental care or more hearing. In a number of for example managed care

models and certainly this is true in the case of some eligible demonstrations, people are leveraging some of their broader flexibility to cover things that have not historically been covered either in traditional Medicare or even in Medicare Advantage Plans and so we may over time have some additional data that might inform coverage policy more broadly but a lot of those coverage decisions in certain cases might require statutory changes.

MR. GOLDMAN: I want to come back to something Greg said that's motivated by that, which is he talked about incentives for innovation, it turns out that some of the early work in delayed aging actually it started to follow the resveratrol hypothesis, so for those of you who know if you – resveratrol is the substance in red wine and you all know that if you feed mice resveratrol they live longer. By the way you have to feed them the equivalent of 100 bottles of wine a day. Drinking it's kind of funny, but the point was they are trying to discover super resveratrol compounds and so they wanted to do clinical trials but because Medicare won't cover it if they give it to health people, because the FDA won't let them do a trial, they ended up doing a trial in type 2 diabetes. And it didn't work and some people have argued that's not the right biology. You want to do it in healthy patient so is there a concern that the way the playing field is tilted against prevention it's affecting biomedical innovation.

SPEAKER: Yes, absolutely and I think that you hit the nail on the head when you brought in the regulatory aspect of that and everybody at the FDA and the biomedical scientists are used to designing medical trial that identify the patient population that is most likely going to benefit from the treatment. It's a very disease focused system and it's really hard to get a new paradigm of thinking of how would you design something that is preventive in a healthy population. Part of the challenge will be well then what is the outcome and how long would that clinical trial have to be in order to measure that outcome and then all of the complications within how would you pay for it

and who would be willing to cover it. I think I came up with Savaldi a little bit on just the latter part where there was a clear benefit but for some of the commercial plans it was, yeah, but the average length of time that people are in our health plan might be two and a half to three years. The benefit, if we're going to pay really a large price for a drug that might ward off liver failure that happens five to 10 years down the road why would we bear that cost when it's most likely that person would be in a different payer system. Those are tough questions to address but we need to.

MS. NELSON: Hi, I'm Katherine Nelsen the housing economist whose focused on needs for affordable housing and most recently on better estimates of those needs among the disabled, but I'm asking an entirely different question. My husband died of lymphoma last August and the fantastic support we received from friends then and since that I've received means that I've had many, many, many discussions about end of life issues and my husband chose hospice and we had a very good death. With regard to your underlying demographic projections, whose studying changing opinions or existing opinions and the possibility of change about hospice and extraordinary desire to stay alive as far as your breathing but not in any other way.

MR. GOLDMAN: There was a very provocative IOM report that just came out on end of life care and I urge you to look at that. I think that's going to be the basis for a lot of discussion about how we go forward but I'm going to defer to the other panelists. Do you have something you'd like to say about end of life care? I don't want to pressure you.

MR. HARRIS: I'm going to say something that I wouldn't have probably said three weeks ago, but it's probably wearing more my primary care doctor hat than the other. I think we have a lot of work to do for people to have conversations between – to encourage people to have conversations within their families as it sounds like you all did

between patients and their doctors. And I think a lot of that needs to happen at massive scale before we'll be ready to have a robust public conversation. There are organizations that I think are trying to facilitate that happening, I've even heard of people in faith communities now starting to have those conversations, but we clearly tried and failed miserably to have a public conversation and I don't think we're quite ready but I think a lot of conversations in families and in small groups and communities and with doctors will be important before we are ready to have a full (inaudible) public conversation.

MR. GOLDMAN: I don't want to attribute any policy on the webinar to Leonard Schaeffer but I think I heard this from him, which is one way of starting this conversation is to have advance directives and if you want your Medicare eligibility you have to at least talk about an advanced directive or opt out if you want. And you can even tie it to renewal and do you think that would be one way to get the conversation started?

MR. HARRIS: I'm hearing that for the first time. I would want to think about that more.

MR. GOLDMAN: I am putting you on the spot, I also put Leonard on the spot, any other questions? Okay, well I just want to thank our panelists. We appreciate your time and we'll take a break now.

MS. RIVLIN: We are remarkably ahead of schedule, but please return in 15 minutes.

(Recess)

MS. RIVLIN: Ladies and Gentlemen, Ladies and Gentlemen, may I have your attention? We'll get back to work. Always difficult after a break, but the first panel set things up extremely well and now we're going to talk about real policy options, and we're going to begin with eligibility benefit design and financial support. So, I will now

turn it over to Henry Aaron and ask him and Marilyn Moon and Bob Reischauer to come up the podium.

MR. AARON: Thank you very much, Alice, and thank you very much for inviting Bob Reischauer and me to do a paper for this event. Bob and I, in turn, want to express our appreciation and recognition of the splendid work that's been done on the very topic we address by a number of people, including some who are here -- certainly Bob Berenson; Marilyn Moon, who is a discussant on our paper; Karen Davis, whom you all know; Tricia Newman at the Kaiser Foundation; and, as Bob pointed out, the entire crew at MedPAC -- members and staff -- who have added so much.

The health care industry has undergone revolutionary change over the last 50 years. It offers a dramatically better product to people than it did in the past, both cures and treatments, some not even dreamt of half a century ago.

It does so also at stunningly higher cost than anyone ever dreamt of 50 years ago. I remember Joe Califano, Secretary of what was then the Department of Health, Education and Welfare in the late 1970s ringing his hands that health care costs had reached the astronomical level of 8 percent of GDP.

Third, medical knowledge has expanded so much that no practitioner can possibly master more than a modest fraction of what is known. And that fact has spawned specialization, which in turn has generated other effects; the need for coordination of care among independent specialists; and changes in the organization of the delivery of care, which is still in its early days but is certain to result in the delivery of care of every larger and more integrated organization.

All of this is happening incrementally. It promises to continue to happen incrementally. And if one wants evidence of incrementalism, the best place to look -- in my view, the strongest evidence is actually the Affordable Care Act, which, far from being

a radical breakthrough that some of its critics charge it with, is in fact actually quite conservative in building on established institutions to expand coverage.

Medicare itself is a vastly better program than it was at its inception. The benefits are better. If you need evidence there, simply say two words: "Part D."

Medicare Advantage provides beneficiaries with broadened choice among competing health plans in addition to the continuation of traditional Medicare.

Medicare Advantage is now enrolling roughly half of new enrollees and serves nearly a third of current enrollees. Furthermore, Medicare has pioneered in a number of ways, most notably in prospective payments.

But Medicare can still be improved incrementally, and that is what our paper is about. So, what are the problems that need to be dealt with?

For starters, Medicare is actually less generous than the typical private insurance plan offered by large employers, and it's less generous in one particularly undesirable way, specifically that it lacks stop-loss protection. In addition, the A/B/D division in traditional Medicare is, let's be frank, and atavism. It serves no useful purpose; it's complicated and confusing; and it actually hinders care coordination.

The evident desire of most people for more protection to fill in Medicare's gaps is apparent, because the vast majority of enrollees in traditional Medicare seek or receive some form of wraparound coverage, and that further adds to complexity, but to make matters a little worse, Medicare actually cross-subsidizes such coverage, because Medicare bears most of the added cost for care induced by such supplemental coverage.

Well, how do you deal with the problems? There are different ways to do that. Simple and incomplete, least satisfactory, and simplest would be to retain the current framework but require that Medigap plans contain stop-loss protection.

Somewhat better would be to add that stop-loss protection directly to

Medicare itself, and the reason it's better is that one could have the stop-loss protection be income related, something that we now are able to do because of the administrative demands placed on various programs, including through the Affordable Care Act.

Better still would be to offer traditional Medicare as a single plan encompassing Parts A, B, and D with unified administration, a single premium, and cost sharing. Bob and I call that a unified traditional Medicare.

Best of all we think would be something we called unified traditional Medicare Plus, modeled actually on a proposal Karen Davis advanced quite a long time ago, that would, in addition, include coverage now offered through Medigap plans in this Medicare coverage, but it would be financed by additional premiums or cost sharing or both so that the plan would not add to the net costs of taxpayers. Bob especially is keenly aware of budget pressures, and we think those need to be taken into account.

Conspicuously absent from our list is premium support, the name that Bob and I gave to a proposal, 19 years ago actually, under which Medicare would gradually transition into a system where each Medicare enrollee would receive a certificate or voucher for the purchase of insurance in a quite carefully and heavily regulated market.

We omit premium support not out of any criticism of Medicare Advantage, which actually shares some of its features and has widespread appeal. It's operating well, and it might well operate even better with some changes, particularly in how the bidding for Medicare Advantage plans is done by various companies. We briefly described some of those in our paper, but that topic is central to the Rivlin/Daniel paper, which you will be hearing presently and so I'm going to pass on from that.

Nor, let me stress, do we omit premium support because we think a system along those lines would never work. We omit it, rather, from our list of current

reforms because we don't think it should be considered now for two reasons. The first is that the experience under the Affordable Care Act exchanges has been, to understate matters, a bit rocky; and major implementations remain. Furthermore, it's important to recognize that the Medicare population would pose far more daunting challenges to administrators than do those currently enrolled under the Affordable Care Act.

The second reason is that choosing among insurance plans is really very, very hard. Research has indicated, not once but on a number of occasions, that even people who are fully competent consistently make inferior choices not in their best interest, and dealing with insurance billing in addition to that is quite daunting.

Third, the ACA exchanges have powers to simplify insurance offerings and to promote informed planned choice, the kinds of regulatory measures we had in mind when we wrote 19 years ago. But they have yet to demonstrate that they can effectively use them, and we think that capacity should be demonstrated first.

Also not included on our list is any proposal to increase the age of eligibility for Medicare. Some have proposed raising it, for example, to age 67 in what I believe is the deeply muddled belief that when Congress in 1983 raised the age at which unreduced Social Security benefits are paid, also from ages 65 to 67, not fully implemented, legislation provided a rationale for delaying the age of eligibility for Medicare.

In fact, the changes in Social Security left the age of initial eligibility for Social Security unchanged at age 62. It left the age in which maximum benefits could be paid at age 70. And by saying that benefits formerly paid at age 65 would be available only when somebody reached age 67, what it did, pure and simple and nothing more or less, is it cut benefits. Most people, in fact, claim Social Security well before age 65. Just as an aside, that's a costly mistake. Shouldn't do that, but I digress. (Laughter)

The central point here is that raising the age of eligibility for Medicare without simultaneously making people over age 65 eligible to buy insurance through the health insurance exchanges and, at the same time, greatly increasing the tax credit support for that age group would impose a devastating hardship on all but those with the highest incomes and especially on those whose physical and mental conditions force them to leave the labor force before age 65.

So, that in a nutshell is our paper. I have just one final comment. The health system has changed remarkably in the last 50 years, but you ain't seen nothing yet. So, I fully expect there to be a similar conference at the centenary of Medicare's birth. (Laughter) Given her track record to date, I fully expect Alice Rivlin to be organizing that conference. (Laughter) And I have to say I hope she invites Bob and me to write a paper for it and that we can do so. Thank you. (Applause)

I am supposed to be sort of a quasi-chair, and in that capacity it's my pleasure to introduce Marilyn Moon, who has kindly agreed to be a discussant for our paper.

MS. MOON: Thank you. It's a pleasure to be here this morning, and I must say it's a pleasure to have read the paper by Bob and Henry. I'm glad to see they're coming around to my way of thinking a little more than they were 19 years ago when they did premium support. Gee, has it really been that long? That's kind of scary, isn't it.

So, as you might imagine, there are many areas of agreement that we have that I'm going to talk briefly about, and then I'm going to talk about three areas that I think may not be even areas of disagreement but perhaps embellishment that I think are important to do.

First of all, I certainly agree with the concept of incrementalism. As I said

a little earlier to some people, the longer you work in the health care world, the less convinced I am that massive change is a good idea. We never know exactly what is going to happen from even relatively small incremental changes, and as a consequence if we go out and try to really throw everything out, we are going to throw the baby out with the bathwater.

So, problematic as it is in many ways -- and I would agree with that -- Medicare is still better than many of the alternatives being proffered out there, and that's something that I think needs to be kept in mind. The key question for me is who will be the innovator that protects beneficiaries, and I see no signs as yet that the private sector is ready to step up to that role. Certainly, some are. There are certainly examples of really innovative and wonderful systems, but taken as a whole I would still put the federal government up there in terms of being a better protector of beneficiaries, which I think is a key issue that ought to be one of the criteria that is used in terms of determining what to do.

I also think that before we rely heavily on competition, we need to focus it and control it in better ways. Competition can lead to really good things. As a trained economist, I do believe that. It also leads to pretty whacky and terrible things as well in some cases when you people competing for the wrong reasons in the wrong ways, and unfortunately, particularly in something as complex as health care, it is often easy for that to happen and to convince people that it's a good idea.

The second area of agreement is that simplification is very important, and I agree that Medicare structure is one way in which that simplification ought to take place. And supplementation and the fact that we have this crazy patchwork quilt, in addition to all the supplementation that currently exists for people like who are still working, but Medicare is primary and I have secondary retiree insurance from my

husband, and I have a flexible spending account, I can tell you that the number of catch-22s out there are unbelievable when you try to wind your way through that system, and on break I'd be happy to regale you with that.

But I think it's also important to point out that there are silos that are created not only by fee for service but by the profit mentality that is out there, the let-me-do-it rather than this other provider, and that whole barrier to coordination of care and the complexity that that adds -- my husband recently had a stroke, and what it means is I know now the difference between neuro-ophthalmology and neuro-optometry and neuropsychology and neurologists and they all want to do the same things in many cases, and they're all convinced they do it better than the other guy -- in many cases guys. And as a consequence, it leaves the individual to figure this out. I'm not sure that a fully coordinated system, in terms of some of the managed care environments, has handled this very well as yet either.

Number 3, in terms of areas of agreement, sliding scale catastrophic cap I think is important. It's the only way to try to protect low-income beneficiaries in an affordable way. When people talk about a catastrophic cap that seems more affordable, they're talking about 7 or \$8,000 in many cases. That's beyond catastrophe for most modest-income beneficiaries that are out there, and there are lots of them in the \$20,000-a-year range, and that's just asking way too much of them.

Fourth, I think we should definitely reform the Medicare Advantage program along the lines that Henry and Bob talk about in terms of payment. And I would emphasize that we need to bring those plans under greater scrutiny and uniformity. There is some variation that you want to encourage and have competition on; there are other kinds of competition you don't want, and that's more the nefarious type where people are promising things that are not really good to promise in terms of differentiation.

For example, promising people first-dollar coverage for certain kinds of care but high co-pays for things like home health care, which is the last place you should be putting on additional co-pays, it seems to me, is something that you should keep in mind. And that's what happens in some of these private plans. It sounds good to the healthy, who they are there trying to attract to enroll in the programs, and then it becomes a big disadvantage for people who get sick and stay in these programs.

This is particularly the case with chronic care needs. Medicare doesn't do a great job, but an awful lot of private plans don't do a very good job either, even just looking at their cost sharing much less some of the ways in which the coordinate care.

Fifth, we should recognize the role of the federal government in quality and disseminating good practices. If private plans come up with good ideas, they don't want them to be proprietary, and they're not necessarily going to share. And that's something we need to keep in mind whenever we talk about relying upon the private sector.

Now, my three points -- I probably have gone over, but I'm going to still give my three points anyway.

Inadequacy of post-acute care. Our post-acute care system, which is really important for seniors, particularly as they age, and persons with disability is, to use a very technical term, crappy. There is a very poor amount of coordination. The handoffs are terrible. The knowledge of people in the system about the other parts of the system is very poor. There's a lack of imagination in terms of what could and should be done. And this is an area where I think we could actually see prevention. Better post-acute care will prevent a lot of other later problems, and we don't do it very well. One of the worst offenders is the limit on rehabilitation services, that there's this dollar limit and when you reach that dollar limit it doesn't matter whether there's a lot to be done still or

nothing to be done. That's the end of that for a lot of individuals.

The second area that I would stress is we have to do a lot better with low-income protections. They are very problematic. For the most part, the most generous low-income protections are at 133 percent of poverty or lower. The only exception is Part D, which goes to a massive 150 percent of poverty. When these protections were put in place, if you do just inflation and think about what would have to keep up with incomes in order to pay the same out-of-pocket costs to provide the same level, then you're talking about essentially saying we should have low-income protections of something over 200 percent of poverty at a minimum. This is a disgrace. It is something that is very difficult for a lot of low-income individuals to work within the system. And the problem is, though, when you take it up to 200 percent of poverty, you're talking about a great number of beneficiaries since there are lots and lots of them that fall into that category.

But, nonetheless, I think this is an area -- and if I had extra dollars to spend, and there are not many extra dollars anyone wants to talk about these days -- that's one of the places I would put it very early on, because those are the folks who need it the most.

I have a lot of objections about some of the problems and the lack of coverage of Medicare, but I can pay, and an awful lot of people out there can't.

So, that brings me to my last point, and that's one that is going to make me unelectable, but that's fine because I'm not running for anything, and that is that there is a need for more funding. We cannot make the changes that are necessary in this program in a fully cost-neutral way. We cannot, for example, trade off improvements in catastrophic protection by raising cost sharing lower down. Cost sharing is already pretty high for this population, and we run the risk, then, of what I see as a problem with the

ACA that gets attention nearly every day, and that is when you have very high deductibles and very high cost sharing, people find that they're under-insured and they're not using health care services. We're close to that with Medicare, and we could make it a lot worse if we trade off, for example, substantially increasing cost sharing for individuals as a tradeoff for getting catastrophic protection. I think that that's the wrong way to do it.

So, without more funding, we're likely to do what I would claim again in another very technical term, "whacky" things to the health care system that we have. There is a temptation to cut in some areas to fund in others, and we may need to do that in some ways when we may need to be smarter about certain kinds of things. But before we instantly assume that every change must be cost neutral, I think we need to think about where there are ways in which we can add some additional funding to this program. We are going to more than double the number of people on the program, and right now it's not too bad, because Medicare isn't growing very fast, but one of the dirty little secrets about that is because it's absorbing enormous numbers of 65- and 66-year-olds who are healthy. And when they get to be 75 and 76, they're not going to be so healthy any longer, and the cost curve is going to go up again, even if we find very reasonable ways to hold down costs on other grounds.

So, I think we have to look forward. Unfortunately, years ago I did a little talk in which I said, Tax me now, because as a baby boomer I am at the height of my earnings power and you can get me before I go onto Medicare. Didn't happen. Didn't tax me as a before age 65 baby boomer. Nonetheless, I think we should still think about ways in which we can add some additional funding to this program to keep it the quality program that it has been over the last 50 years and to make sure that when Alice does the hundred-year anniversary that we are all here to celebrate it and talk about how it remained a quality program serving the people that it is intended to serve. Thank you.

(Applause)

MR. AARON: Thank you very much, Marilyn.

Bob Reischauer is going to respond for our team.

MR. REISCHAUER: Well, just a few introductory comment, the first being that I'm going to leave Henry to write the hundred-year paper by himself even if I do take Dana's pills and drink a lot of red wine. I intend to be on the beach at that point and set an example of knowing when it's the appropriate time to leave the stage, like some people. Who knows. (Laughter)

Also a quip about -- Marilyn said she's not going to run for public office and given who's running for offices, I can tell you that she isn't age-disqualified and she does have a very important message, namely, her third point, which is there's no way we're going to do this without spending more money as a society of higher fraction of our GDP to provide adequate state-of-the-art health care to our population and allocate those costs in an equitable fashion across our whole income spectrum.

I'm going to be very brief, and that's because I want as much time devoted to questions as possible, and I reached that conclusion after hearing the comments about the adequacies of Medicare coverage. I'm sitting here with two hearing aids, well over \$2,000 worth and an appointment later this month to have a root canal (laughter), and I have often reflected on how the bottom half of our income distribution can face those kinds of challenges. And of course the answer is they don't, and they live with consequences that are only becoming realized now in the psychological and other literature about quality of life for people who aren't as fortunate as all of us in this room.

This room is filled with a number of people who are really expert on Medicare and could come up here and present as well as we do, and I'm sure all of them haven't noticed and those of you who read the paper later will notice, that we have glossed

over a number of thorny issues. And these issues mainly revolved around how one implements change of the sort that we have been advocating here.

You know, policy formulation or papers like this are really easy to write and easy to talk about, but the tough part is implementation, sort of what can you get through Congress; what can you administerably administer, and, you know, that -- we tried to sort of confine ourselves to things that we really did think over the next 15 years were feasible. But to sort of convince people of this, we would have had to have written a 400-page book, as some people have done, on that topic subject to a huge amount of uncertainty.

It's also worth reflecting on the fact that, you know, the solutions to yesterday's problems also become the impediments to solving today's problems. And if you just think about it, we have, over the last 30, 40 years expanded, standardized, et cetera, the Medigap options, so that is a robust component of the insurance industry, and there will be a lot of reluctance on the part of insurers to changing that as we have suggested and also some reluctance on the part of nonprofit organizations like AARP who have done a lot to stimulate the demand for this and profited from it.

There's also the issue of Medicare Advantage, which started a small, sort of a niche type of operation, and because we had excess payments and folks were receiving ancillary benefits or lower premiums, understandably those in the parts of the country where coordinated care was not economically feasible said, hey, let us into the game.

And we then expanded what you could call Medicare Advantage to private fee-for-service plans and other forms, and they will be an impediment also to some of the changes that we have proposed, not to mention the Part D program that was solving the problem that we had that Medicare didn't cover prescription drugs and to get

them the kind of political support that we needed for that we allowed the private sector to offer plans that really were unlike the plans that they were offering now, which are basically for employer and other purchasers. And they serve as PBMs -- pharmacy benefit managers -- that comply with the integration that the purchaser -- mainly the employer or the union -- wants, and we have this standalone plan, which, as was described by the first panel -- we have a few paragraphs in there about this -- has financial incentives that may be a hundred percent the ones you would want to provide the best overall health care.

So, we have to think about what we are putting forward and where the opposition will arise from and think of ways that can get everybody onboard.

Just to mention two things which we didn't get into, and they're very complex issues, one of them is to think about how we have set premiums for our unified traditional Medicare and unified traditional Medicare Plus points and the extent to which we will tolerate differences in premiums between these plans and the follow-on plans to Medicare Advantage.

And the second really thorny problem, which is whether at some point over the next decades we should begin varying premiums by the differences -- the justifiable and unjustifiable differences -- in Medicare costs across geographic areas. I was a member of the Institute of Medicine Panel on that issue -- not the solution but the extent to which costs vary and what the explanation is, and of course some involved cost of inputs, small, able to ignore largely. Some are the health of the covered populations, some relate to the quality of care, some to the efficiency of the delivery system and the extent to which low-value or no-value services are provided differentially across the country. And at some point, I think if we want to spur efficiency we're going to have to begin to grapple with those questions. But they are not ones that we covered in any

depth in our paper.

So, with that I'll turn it back to our chair.

MR. AARON: Have a seat and --

MR. REISCHAUER: I will return to my chair.

MR. AARON: We will go directly to questions from the floor, because I think each of us talked a little longer than we were asked to do and we've eaten into the time for questions from the floor.

So -- yes, sir. Microphone down here please. And would you identify yourself and end up with a sentence that has a question mark at the end.

MR. ALTMAN: I am Fred Altman. I'm retired. And my question is, you know, one of the options you're talking about is increasing the money going to Medicare. But there a ready concern that we're spending too much public money on the aging at a cost of not providing adequate public funding for younger generations. Do you want to address that problem?

MS. MOON: I personally believe the problem is if you give more money to the aging, then there should be less money for the very high-income population in the United States. I've looked at this issue for years, and even within the Medicaid program where you would see a direct tradeoff potentially, I don't see that if you cut programs for seniors that it translates into higher payments for kids. That's not the way our political system works. When we cut, what we do is then tolerate lower taxes over time and congratulate ourselves that way.

So, I think rather than accepting the premise that we're pitting the old versus the young, we have to think about where we want to have resources and work on that that way. I have no problem, for example, with the notion that if we're going to increase taxation in some way to help seniors that we should do that with an equally

large piece of money that goes for helping children in some way. But I just think it's often this false dichotomy.

MR. AARON: Other questions from the floor. Yes, ma'am. You can come in again.

SPEAKER: Yes, good morning again. With the recent legislation in the past, there was a provision that GAP plans, as I understand them, would no longer cover the 147 deductible. So, I have two questions. One is, is they're really thinking out there that people in 75 and 80s are going to the doctor unnecessarily and this will prospectively make them more conscious? But, second of all, I wonder how many people understand how many GAP plans have age bump-ups. So, you may be paying a certain premium when you first sign in to it at 65, say 2,000 a year, but that may become 3 or 4 or \$5,000 a year at various incremental ages, so they're paying significantly more as the -- so I wonder how many people do you think really understand that and also about the \$147? Thank you.

MR. REISCHAUER: I think very few understand that. I mean, there are three ways in which I am sure can set the premiums for Medigap plans, and, you know, one is the age of enrollment, one is the age of containment, and the other and the third is community rated. And of course people can change from one to the other as they go through talking about choosing a different plan. But I think you put your finger on sort of one of the complexities of this whole area of public policy, which is the vast majority of people have very little idea of what they're buying and what the conditions are. And not to embarrass anybody on the Brookings staff, but I received an email from a prominent Brookings researcher -- I was a Brookings researcher once, so (inaudible) -- saying, How does this whole thing work; I mean, I can't figure this out at all? And it's because it's so complex. And that's why Henry and I and Marilyn before are saying, you know, we

should really condense these things together and give the elderly the same kind of situations that the vast majority of all Americans with insurance have except the elderly and disabled, and that is you buy one plan and it is comprehensive and covers everything, and premiums are set and the method of choosing them doesn't change.

The \$147 and 90 cents I believe -

MR. AARON: But it was going.

MR. REISCHAUER: Yeah, (inaudible) that last 90 cents.

You know, I think, you're right, that that isn't going to discourage a lot of utilization. I mean, you can hardly say hello to the receptionist at the doctor's office without getting billed for \$147. You know, it's basically a way to gain money to use for something else.

MR. AARON: That's what it is.

MS. MOON: I've never believed that the \$147 is going to do anything to change the use of health care services. That said, it's not so terrible as \$147. My concern is if we move to a combined A/B deductible, for example, that's going to definitely be more than \$147, then you start to talk about a 6 or \$700 deductible potentially. And if you're saying no one can buy protection against that, it could become a deterrent, and the unfortunate thing is that's a deterrent where you don't really want there to be a deterrent. The real health care spending occurs when you're well beyond \$600 or \$700 or a thousand dollars. And we need a lot more careful attention to how we're spending, but that's not going to be controlled by individuals worried about their deductible.

MR. AARON: That raises an important point, which is that good insurance, along with higher deductibles, frequently has (inaudible), which are not subject to the deductibles. But the emphasis of the details of the implementation I think cannot

be overstressed.

Just about my favorite quote on this matter dates back to somebody who -- someone in the room may be old enough to remember -- Wilber Cullen, who said that "Good public policy is 10 percent legislation and 90 percent implementation," which is a point that I think Bob was making, and it cannot be overstressed again.

Bob referred to the email that he received. I'm going to describe the lunch table conversation that occurred yesterday that either followed or preceded that email. It involved four or five PhD economists, one of whom had had -- and without blowing his cover -- a high position in the Federal Reserve System, others of whom had held high government positions of various kinds. The whole discussion revolved around the fact that one of these people is going to be going off the Brookings payroll at the end of this month and will thence have to make a decision about whether to take the Brookings supplemental benefit plan, which used to be generous but isn't anymore, very carefully designed to achieve that result (laughter) -- I speak with genuine emotion on this subject -- or one of the plans offered in the commercial sector. And none of us -- none of us -- was able to give good advice or really weigh the choices very well. We all are relatively passive buyers. We're like, in this respect, the Nobel Prize economist who, when asked how he plans his investments, said, Oh, I just put them in the Index funds. This is an area of great complexity. And there is a really deep question here as to how much choice is really optimal for people to have. Some, yes. Too much and people disagree about how much is too much. But it isn't the maximum amount of choice possible. This is a very complicated area and one in which the design a policy is hard enough; the implementation of policy is even harder.

We are going to be passing on to the next session. I think we've used up all our time here, and thank you, Bob and Marilyn, and we look forward to the next

discussion. (Applause)

MS. RIVLIN: Now we're going to move on to a subject which has already been mentioned, namely, Medicare Advantage. And the possibilities of improving Medicare Advantage and perhaps turning it into what might be described -- I hesitate to use this term -- as premium support.

First a little bit of history, only about five years ago you will remember that there seemed to be a huge politically partisan divide over premium support. Republicans were for it, democrats were for traditional Medicare. My friend, Congressman Paul Ryan, had precipitated this -- he became my friend when we served together on Simpson-Bowles -- because he made a proposal for converting Medicare over time to premium support. It wasn't an original idea as Henry said earlier. He and Bob Reischauer had floated this idea in the 1990s, and it had been featured in a bipartisan commission headed by Senator Breaux and Congressman Thomas, but not endorsed by that commission. The basic idea of premium support was that instead of guaranteeing to pay for a defined package Medicare benefits the government would guarantee a fixed contribution which beneficiaries could use to buy private insurance. The contribution would be risk adjusted, it wouldn't be a single payment or everybody, it would be risk adjusted by agent and health status. Obviously it could be generous or not. And Paul Ryan's original proposal was not. It started like most of these plans by saying the average payment would be the average current payment under Medicare, but then it depends on how fast you grow it. And he grew that contribution only with prices, which would mean steep cuts in real benefits over a few years. He also phased out traditional Medicare. You would only -- if you were coming newly -- if you were a new beneficiary of Medicare you would only have the premium support option.

Well, there was huge furor about that and a wonderful video in which a

Ryan-like figure pushed granny over the cliff you may remember. One of the most defective political ads I've ever seen. And democrats rejected the whole idea of premium support, identifying it with the Ryan Plan, and rejected including some much more moderate and sensible bipartisan plans, one of which I worked on with Paul Ginsburg and Pete Domenici, and another that Ryan himself worked on with Senator Ron Wyden. But it sort of dropped off the radar screen, the furor died down. But meanwhile something interesting is happening. Choosing plans is becoming a more familiar part of American healthcare. The ACA has people choosing plans on exchanges. It isn't working perfectly yet, but it's becoming a familiar idea. Part D of Medicare has the whole Part D population choosing among plans. And there is Medicare Advantage which is a popular program, partly because as Henry pointed out, it had been subsidized. But it has grown in enrollment even as the subsidies have been cut back, and it does involve Medicare beneficiaries choosing among private plans. So a possible idea is forget premium support, but why not start with Medicare Advantage -- an idea that Paul Ginsburg actually suggested to me when we were working on the Domenici-Rivlin Plan, but I said, no, can't do that. But here it seems maybe not such a bad idea.

Now my colleague, Will Daniel, and I wrote this paper to exposure the advantages and the disadvantages, and we'll emphasize many of those, of introducing more competition among health plans into Medicare by reforming Medicare Advantage. And specifically in this paper we analyze two ideas. Plan one would change the way that Medicare Advantage plans are priced, and would go for competitive bidding against each other. Plan two would broaden that competitive bidding to include fee for service medicine which would be considered a plan coming in at the average cost in the area and competing with the private plans. Now that's a form of premium support in which the government contribution would then be the competitively determined price of producing

the Medicare benefit package in a particular area.

So briefly, how does Medicare Advantage work now? The benchmark for bidding is the average fee for service cost in the area, and the area is normally a county. Private plans submit bids for delivering the Medicare package, and that is presumably the cost at which they could do that, but they are actually paid their bid plus a portion of the difference between that and the benchmark or the fee for service cost. And they can use that difference to cover extra benefits or to lower cost sharing.

Now the paradox of the cost of Medicare Advantage is if you're against Medicare Advantage you say that because of these subsidies and because of the way the bids worked the average payment to Medicare Advantage is higher than fee for service, and that's true. If you think Medicare Advantage isn't such a bad thing, then you point out that within areas the bids for Medicare Advantage are lower and the cost for Medicare Advantage is lower than fee for service. Now how can both those things be true? It's true because the Medicare Advantage plans can underbid fee for service in the higher cost urban areas where healthcare is expensive. And those are here the highest proportion of Medicare Advantage enrollees live. And also because under the current law the Medicare Advantage plans are subsidized in low cost areas.

So supposed we change these rules a little bit. Our plan one, which you would set the Medicare Advantage price by competitive bidding among the plans themselves would lower the cost of Medicare Advantage by all the evidence, especially in high cost urban areas. But it would raise two big issues which would also occur in plan two. One is simply whether to subsidize rural areas. We know that it would be necessary to do that to have plans competing in the rural areas. Do we want to do that or not? You could say let's forget those, that's where traditional Medicare works, and we won't bother to subsidize private plans in the lower cost, mostly rural areas. The other

big question is how well competition will actually work in the very concentrated markets, and they are concentrated, in which insurance plans operate. That's a big problem for the ACA; it would occur here, does occur here as well.

Our second plan would broaden that and say let's include fee for service as just another plan. Let the fee for service average cost be an option and let the Medicare Advantage plans bid against that. That would by all the evidence lower costs further because there are certainly areas in which the lowest plan or the average of the plans would be lower than the fee for service cost. But it would raise two further problems. One is risk adjustment, which is an imperfect art. In general Medicare Advantage enrollees are healthier, and they tend to shift to fee for service when they get sick which is not surprising because that's when you need a broader network and more choice. And the second question, which is sort of the basic philosophical point about Medicare, is what is it that we want to guarantee? Is it a particular package of benefits which can be delivered either under fee for service or under-capitated plans, or is it wanting to have -- stick with a network that you're in or a doctor that you're with. If you allow our plan two type competition then in order to stay in your network or stay with your doctor you might have to pay more.

So our conclusion is a very cautious one. If we can solve those four problems we could have a more efficient lower cost system, but they are hard problems to solve. But one thing to keep in mind is that, as we'll talk more about in the next session, traditional Medicare itself is evolving. It is possibly moving toward integrated capitated plans, and plan which accept risk. They may not be that different in the end from insurance companies. So we might end up, if we pursue these tracks, with choice among plans being a normal, with integrated capitated systems being normal, but they'd be different kinds. Some of them would be run by providers, some of them would be run

by insurance companies.

Thank you. And now let me turn to our two able discussants, the first of whom would be Jim Capretta. (Applause)

MR. CAPRETTA: Good morning. Thanks for the invitation to be a part of this. Thanks you to Alice for inviting me to look at your paper and comment on it. I enjoyed the paper, and very glad to be here as part of this long discussion today about Medicare and its future.

I want to start by picking up a little bit on some of the things that were said in the previous panel and here by Alice. With respect to the fee for service program and why Medicare Advantage becomes an option, I think it's sort of easy for us to bemoan some of the shortcomings I think of Medicare Advantage, but I think Medicare Advantage really has emerged and is a large part of the program now in large part because fee for service has its own sort of problems. And I think the way to understand that is think of, you know, if you have a fee for service program designed by any private insurance system they would by definition have cost sharing associated with it because the way fee for service is supposed to work is that the provider decides that a service is needed. The beneficiary goes to that provider, has a problem, the provider decides that a service is necessary. The insurance component is essentially supposed to pay the claim no questions asked, right. I mean that's the way fee for service was thought of for very many years. And so if you don't have cost sharing associated with that then the third party payer, in this case the government, pays out claims in an unlimited basis. Anything that provider decides is needed and the beneficiary is willing to take would be provide and it would cost the third party payer. So in the designed Medicare of course they imposed cost sharing. That's the only check on use in a fee for service system. The follow on to that though in Medicare is that of course the very, very risk adverse

population of the elderly immediately wanted more protection than the benefit provided in Medicare. And so very quickly a medigap market emerged as did employer wrap-around insurance. And so for the vast, vast majority of cases, going back decades now, the Medicare population -- even the statutory cost sharing has been quite high, the amount that has been paid at the point of service has been very, very low. The percentage of the population in Medicare fee for service that have been exposed to the statutory cost sharing is probably in the range of less than 10 percent of the fee for service population because the vast majority have either an employer wrap-around plan or they bought a medigap coverage. Now in the last several years we've tried to move toward restricting how much that medigap plan can cover with some modest changes, including the one that just got enacted. But the vast, vast majority of the situation is that fee for service is still essentially at the point of service a no cost sharing program for the vast, vast majority of participants. This explains Medicare fee for service. This is why Medicare fee for service for decades has been a high volume, high intensity program that more than any other factor in the United States medicine has contributed to fragmentation and overbuilding of the medical delivery system. Lots of people bemoan that, but I'm just trying to explain that Medicare has been a big contributor to that. So it's because of that phenomenon we have a very risk adverse population. We understand they would love to have zero cost sharing healthcare, but you cannot have that with a passive third party payer system. You have to have an active third party payer system. And by definition that was more developed on the private side than the public side. And so private insurance has stepped into that breach to some degree and become the mechanism for trying to manage more of the care. So that essentially explains I think why Medicare Advantage has grown.

Now a couple of things to follow on I think relative to the paper from

Alice. There's an interesting article that was published in the *Milbank Quarterly* two years ago I believe or so by Newhouse and McGuire that went through many of the same issues that Alice has raised as concerns about competition and the way to set up competition between the programs. And I just want to review a little bit of what they found. I think with respect to risk selection there have been a lot of studies recently that try to show that as you move toward identifying higher paid diagnoses and adjusting for that within the payment system, Medicare has done that to a fair degree in the last decade, that the new research is saying well that may be true, but then you also find that they risk select within a payment or within a higher risk category. In other words the insurers are adept at figuring out the high cost case that actually is a little bit lower cost is the idea. You find someone who is going to pay the high risk adjustment and then you find that patient that yes, they're going to get that high risk adjustment but they're actually a little healthier than the normal for that big risk adjustment. And so they identify that kind of patient. Well, I think that there is probably some truth to that, insurers are pretty adept people, there's no doubt about it. But of course the presumption in these studies has all been that the managed care plans, the HMOs, are not better at all in managing the care. They presume the entire differential for taking that higher risk patient is assigned to better health, not to any kind of management of care. Now there may be, you know, arguments about how well these HMOs are actually managing care in the private sector, but I very much disagree that it's zero. So that there's going to be some element of this which is associated with actual management of care.

Another issue they raised in this comparison of how to get to better competition in the Medicare program was something they called -- and I very much agree with -- which is the non transparent price competition that already exists between Medicare Advantage and fee for service. Right now what happens is if you sign up for --

well, if you're on the Medicare program your Part B premium is entirely withheld out of your social security check. So that's a big part of the price of the Medicare program. Medicare Advantage is allowed if they want to price compete with fee for service and offer a rebate against your Part B premium. The problem is the rebate actually has been put back into your social security check. Now that may be a good thing. Your social security check might go up \$50 a month if you selected a very low cost Medicare Advantage plan. But lots of economic evidence indicates that if someone makes the selection and then the reward for that is showing up in a third transaction that they barely pay attention to, they aren't really price sensitive at the point they make that decision. So what you probably need to do is have the Part B premium paid entirely by the beneficiary and then allow more direct price competition between the MA plans and the fee for service coverage. At that point you will get, instead of huge bunching as you do now at zero premium plans, you might actually get some of the MA plans bidding even lower and driving down the cost below what they're doing today.

I've run out of my time, so I don't want to abuse Bob's time. I have more things to say, but I'll save that for some other discussion. Thank you very much.

(Applause)

MR. BERENSON: Thank you. It's a pleasure to be here and I will not take some of the bait that Jim threw at me and we'll stay with some of my prepared remarks.

The first one will be to come at it completely from left field and it is to take some issue with the terminology of fee for service Medicare, and maybe this will demonstrate that I'm really an old curmudgeon. But it extends a caricature that just isn't true. Even the Medicare fee schedule for physicians we now know that about a quarter of the activities that primary care physicians do aren't paid for. They don't get -- I mean

fee for service is usually defined as the provider gets paid for every item and service they provide, but it's certainly not true for hospitals. Diagnosis related groups is not fee for service. It is volume related and that is the issue. There is an incentive for generating more admissions, more readmissions. The reason I'm sort of quibbling about the terminology is that I think it leads to some sort of muddled thinking. So DRGs for how we pay hospitals is -- that's the old style. We're going to have payment reform, we're going to have bundled episodes in which we sort of pay a bundled amount for a doctor and hospital together for providing an episode of a hospital care. That's one of the models. Somehow that is not volume based, that's a payment reform. What we might get out of doing that is a very efficient focus factory to give patients high quality efficient care for something they don't need. And so the point I'm just making here is that as Alice said in her remarks, traditional Medicare is evolving and that's what I want to spend the rest of my comments on is to talk a little bit about the interactions between traditional Medicare and Medicare Advantage that set let's say challenges or that need to be kept in mind in thinking about any competitive structure, especially one in which traditional Medicare would be competing with Medicare Advantage.

They both talked about risk adjustment and I've taken this opportunity to actually start catching up on the literature and there is a very vibrant literature going on now about risk adjustment and its relationship to Medicare Advantage. And briefly, my take on what's going on is that yes, there still is favorable selection in plans, that we're still not able to fully adjust for. The variations in different studies is pretty significant from -- at four percent to mid teens in terms of how much favorable selection there is, but Newhouse's group in particular are pretty reassuring that we're able to capture a lot of the risk differences. But what hasn't gotten much attention until very recently, and there is now one very important study by Kronick and Welch coming out of ASPE about the

problem of coding intensity, which is that the beneficiaries in Medicare Advantage have whatever risks they have, but the health plans have figured out ways to code much higher levels of intensity for those people so the payment is much higher. And that seems to be a growing issue. And there's just a study out by Geruso and Layton in the National Bureau of Health Economics which is finally finding what some of us were quite concerned about, which is the association between coding intensity, meaning higher payment and the degree of vertical integration, meaning the closer you get to the providers who actually check the boxes on the codes, the more likelihood you have that you're going to see higher than real codes. Or I won't necessarily make it pejorative, higher codes than the comparison which is in traditional Medicare.

And so one of my concerns about ACOs had been that they would be able to aggregate market power in their negotiations in the commercial sector when they negotiate with health plans if you sort of sanction vertically integrated systems. I think there will be an increasing challenge both within traditional Medicare but also in any kind of level playing field discussion of competition about the ability to adjust for this demonstrated ability of coding intensity. Now the Welch Kronick paper does demonstrate that CMS isn't helpless, but they've made some changes and they can detect -- you can -- in fact what is going on is a coding intensity adjustment that applies across all plans. The problem is some plans are much more aggressive in this area than others. And so we have sort of rough justice going on. So risk adjustment remains a major challenge.

The next topic I want to take up is one that doesn't get much attention at all and it's work that I'm now involved with. I hope to publish in the very near future a study which sort of demonstrates the reasons why it is that Medicare Advantage plans pay hospitals basically at Medicare rates. The assumption had been by very smart people, and I'll put myself in this category, that the private health plans pay commercial

rates and therefore face a major pricing disadvantage in comparison to traditional Medicare. Well, it turns out that there's this rule in the statute and then in regulations that says any patient who goes outside of their Medicare Advantage plan and sees a patient in traditional Medicare is paid at traditional Medicare rates. That completely changes negotiating dynamics. The provider, the hospital provider can either be in network at Medicare rates or out of network at Medicare rates essentially. Another factor we heard as to why this phenomenon happens is that there is real competition in Medicare Advantage with -- guess what, traditional Medicare. If the hospital said we need 160 percent of Medicare which is not atypical in the commercial sector, the MA plan is in a position to say we can't compete with traditional Medicare or with other MA plans at 160 percent. It's just become pretty well established that MA plans benefit from traditional Medicare. And in fact CBO has provided some estimates that if traditional Medicare disappeared there would be a migration up in the rates that the private plans were paying to hospitals. We know very little about the pricing in all the other structures. I would say we need to understand that a lot more in thinking about how we would structure a level playing field.

I only have one or two minutes to go so let me just tick off three or four other items that I think are in play when we think about level playing field competition. First would be three stop shopping versus one stop shopping. Right now in the system if you want to stay in traditional Medicare you've got one entity traditional Medicare for your medical services, you have a medigap plan, and you have to go by a Part D plan. It's a lot easier to do one stop shopping. And so one of the real benefits I think to your guy's -- what is it -- unified traditional Medicare plus is to sort of even that sort of choice phenomenon. I never believed we would see a drop off in an enrollment in Medicare Advantage partly because this advantage that was created, partly because the new

generation of people moving into Medicare are much more used to dealing with networks and know to navigate a little better. Marketing costs, I mean clearly this goes in the other direction. Medicare Advantage plans I think have a legitimate point to make that Social Security Administration, the Post Office, everybody else, is capturing some of traditional Medicare's marketing and enrollment costs; Medicare Advantage plans have to bear that. So that comparison is a little unfair.

One of the real problems I would argue that traditional Medicare has is the lack of administrative support to manage its own program. There's an artificial limit on how much traditional Medicare has for administration, it's based on appropriation, they can't tap the mandatory side trust fund to spend money to save money. So the GAO report last week that came out that basically bemoaned how CMS was doing with the Medicare physician fee schedule in traditional Medicare pointed to the fact that there were 10 people at Medicare and therefore Medicare is overly dependent on the American Medical Association and all those docs out there for free labor. Medicare has no choice. So clearly we have a level playing field issue there.

And the final thing I will mention, and I'm happy that you guys in your paper mentioned it, is this issue of new technology coverage. Most people don't know that private plans, Medicare Advantage plans, actually have to follow Medicare coverage policy. They can't do what Mark Pauly has recommended. I'm not sure I agree with this, but he basically says a plan should be able to market last year's benefits at last year's prices, be able to distinguish themselves based on what they are covering. It came up in the first panel this morning, a couple of different CMS administrators -- Gail I believe was one of them and Nancy Ann was another one -- attempted to sort of bring some notion of value in the coverage process. Mark McClellan tried with coverage with evidence development. Most of that stuff is on the shelf at this point. Medicare doesn't have a

very disciplined process, not just for doing cost effectiveness analysis, which as you pointed out isn't something that the program can do, but just effectiveness analysis. And private plans sort of have to live with that. I think it's an area that both traditional Medicare and MA plans would benefit with a relook at how that is all done.

And I'm over time so I'm stopping. (Applause)

MS. RIVLIN: If we're not to shortchange the last panel we have to move onto questions for which we have a short amount of time. Wait for the microphone and tell us who you are. Yes?

MR. GUTERMAN: Hi, I'm Stu Guterman with the Commonwealth Fund. And I've noticed that in a lot of discussions of premium support or whatever people decide to call it, the concept of quality gets left out and all the emphasis is on price. And I wonder if for instance if you decided to set the benchmark price at the average for all the four or five star plans in an area, whether that would change the picture. It would certainly emphasize the high quality plans rather than just all the plans in the market.

MS. RIVLIN: Right. I was remiss in not mentioning quality. There has been a considerable effort to grade as you noticed, to grade the Medicare Advantage plans and give them stars and give them bonuses for getting five stars which has arguably helped offset the declining subsidy and may explain why there hasn't been as much exit as there might have been. But that's an interesting idea, to emphasize quality even more in setting the competitive bid regulations.

MR. BERENSON: I would just comment that there is a significant correlation between health plan quality scores on the star ratings and the underlying delivery systems, geographic delivery systems. In Massachusetts you have a much better chance of having a high star plan than if you're in some parts of the south. So I think we'd have to be a little more careful about -- so I guess the point I'm making is the

plan in Tallahassee that is a five star plan is really doing something different than perhaps the plan in Massachusetts is doing. I think that needs to be taken into account on anything like this. I don't think we have the quality metrics that can be used for more than marginal refinements. The final point I would make is its upside only so far in the star ratings. Why not have the lower rated plans actually get less payment rather than -- it has helped with the --

MS. RIVLIN: Penalized it, right.

MR. BERENSON: It has helped deal with the reduction in the payments, but we still don't -- we are still in aggregate payment Medicare Advantage plans more than we are paying traditional Medicare and that could be budget neutral. If we're convinced that those quality measures really are that important; I have mixed feelings about it.

MS. RIVLIN: But hope for the future. I hope that we get better at it.

MR. BERENSON: Yeah, that I -- I always have hope for the future.

MS. RIVLIN: Yes.

DR. POPLIN: I'm Dr. Caroline Poplin. How do you factor in a study from Wharton a couple of years ago that said that the money that was saved from Medicare Advantage was not going for additional benefits for patients, it was going for marketing and profits?

MS. RIVLIN: Well, part of it goes for marketing and part of it goes for additional benefits. And the regulations have moved on that fairly recently, but you do raise the problem of private plans have to market which Bob was saying earlier.

MR. BERENSON: I don't know that study in particular. I mean the bids that plans submit are supposed to reflect their real costs with a limit on what's available for profit if in fact that far exceed that. Then there's another administrative oversight

problem. So I'd be happy to talk to you more about it.

MR. CAPRETTA: I mean 30 percent of the population is now on Medicare Advantage, so the beneficiary population -- it's a complicate choice obviously to join a Medicare Advantage plan. I agree with the previous panel. There's a lot of complexity in healthcare, but I doubt that the trend line would be continuing to go up if it was all just smoke and mirrors. The beneficiaries are choosing it for simplicity, lower premium, lower cost sharing without medigap coverage. Look at the profile of the people that are in Medicare Advantage. They tend to be people who don't want to pay \$250 a month for a medigap premium and can get a pretty comprehensive benefit package with simplicity and relatively straight forward management of their care through a Medicare Advantage. I don't think that's nothing.

MR. BERENSON: Yeah, I would go on -- and I mean this was a point I was going to make but ran short, which is I've been working for years trying to figure out what a level playing field competition would be between MA and traditional Medicare, but I'm changing my thinking a little bit partly from the results of what we know about selection issues, that most people who join an MA plan are perfectly happy in an MA plan; the switching is in single digits. But the people who do switch back to traditional Medicare are sicker and they are going for a particular reason presumably that being in traditional Medicare with more choice or specialized expertise perhaps of some providers who aren't in Medicare Advantage, offers them an opportunity for that time. While they're in Medicare Advantage they are probably benefitting from the greater attention, the chronic care management, some aspects of prevention that traditional Medicare has a hard time doing. So what's wrong with that? Actually that people would be in Medicare Advantage and are allowed to switch back into traditional Medicare rather than thinking about longer lock in periods so that we have purer competition, to see them more as

complimentary. The point I was making about pricing is that if traditional Medicare sort of disappeared or became much smaller we could have a significant increase in prices, or at least we'd have to establish regulatory prices. I actually think having those prices effectively be traditional Medicare prices is a reason Medicare Advantage is as affordable as it is. And that's regulatory approach that in away is supporting competition.

MS. RIVLIN: We've run out of time, so thank you very much, Jim and Bob. And we'll move onto the next panel. (Applause)

MR. GINSBURG: I'm Paul Ginsburg and I'll start this panel on provider payment reform in the traditional Medicare program. A lot that has come before is clearly relevant to our panel. And the interest in reforming provider payments in traditional Medicare has been very broad. Real enthusiasm by policy makers, and we've seen that in the recent SGR fix and the statements by Secretary Burwell about her goals for the proportion of Medicare spending that's in these reform programs, and also a lot of interest in the leaders of providers and the insurance communities.

I think this does have potential to play a very important role in traditional Medicare to reduce outlays and to improve outcomes for the beneficiaries. The issue is will this potential be realized. And I would say that whether we realize this potential is very dependent on making the right changes in Medicare because I don't think that we're headed there right now. And this paper is about charting a course to get there. Now some have commented that these approaches are really just a transition to Medicare Advantage. And certainly some individual delivery systems might have such a perspective. You know, they might see it as an opportunity to prepare themselves to then go further and get into Medicare Advantage as insurers. But we see the ultimate share of Medicare Advantage being dependent on beneficiaries and their decisions as they weigh the cost and quality of the alternatives, hopefully with as level a playing field

as possible. And actually if payment reform in the traditional program succeeds it could even slow the shift to Medicare Advantage as then the traditional program is a more attractive, more efficient program than it is today.

Now the experience to date is that we've had a wide variety of approaches being piloted. And I think that's very positive. In most cases we don't have results yet or many of them have shown small savings. I think the results so far have been encouraging enough to move forward, revise the models, but I don't think it's impaired anyone's conviction that there really is potential in this approach. I think the key variable now and in the future is provider take up. You know, this won't succeed without wide provider participation. And sometimes the emphasis on short-term savings for CMS has undermined the attractiveness to providers.

I think some of the issues that are most serious are the issues of getting the benchmarks straight. Now what I mean by benchmark is what the provider spending is going to be to compare to, to determine whether there are savings or losses for the provider. And the voluntary nature of the pilots to date has really forced the program to use benchmarks that are based on each individual provider's experience spending wise in the Medicare program. And this means that you can only reward improved performance. You can't reward providers for very good performance if they all along had very good performance. So it discourages provider participation in two ways. First if their spending is already low they have less potential to do well and garner savings to share. And if benchmarks either will be or might be rebased in the future, this significantly undermines the business case for providers investing to improve their delivery. And this is a real problem in particular for the bundled payment for care initiative that the Innovation Center is pursuing which rebases the benchmarks very frequently so that plans can have an initial -- providers can have an initial significant reward, but then

getting a further reward in the future is very difficult.

Now there are two solutions to this benchmark issue. One is to avoid rebasing provider specific benchmarks until the whole system is ready transition to community benchmarks. And the other, I think more important, is to bring elements of compulsion into the process. Some reform payment approaches can be mandated. Those where pilots have shown good results and are manageable for most providers. So an example would be bundled payment for joint replacement. You know, that could be made mandatory. And once you mandate payment you could include a transition from provider specific benchmarks to national or regional benchmarks. Also you could pick the rates that generate federal savings based on what providers are expected to be able to achieve. And there also are softer approaches as we see in the alternative payment mechanism provisions of MACRA, you know, the SGR fix. And this could allow -- where physicians are offered higher rates if enough of their practice is in alternative payment mechanisms -- and this could allow the blending in of national or regional benchmarks if many providers respond to those incentives and are participating in such mechanisms. The paper has some discussion about how to choose whether to use a national or a regional benchmark. And the answer is that for population approaches it should be regional and it should align with Medicare Advantage as much as possible. And for episode approaches it should be national to align with inpatient prospective payments.

Another area for improvement is beneficiary engagement. It's really important for providers to have the tools to engage beneficiaries. Have I taken nine minutes already? (Laughter)

SPEAKER: Time flies.

MS. RIVLIN: Four minutes.

MR. GINSBURG: Okay. It's really important for providers to -- I said

that already. (Laughter) This starts with knowing who is attributed and we'd really need prospective attribution to beneficiaries. I would like to see beneficiaries have an opportunity to identify their primary care physician because that defines attribution to an ACO. And in some of the recent models announced by CMS yesterday I think ACOs would have the ability to provide incentives to beneficiaries to use their primary care providers. I think a network approach would be much better. Where the beneficiaries would choose to be identified with an ACO, there could be an incentive from the Medicare program or from the ACO to do this, and that their cost sharing would be lower when they use in network providers and higher if they use out of network providers. So this would allow the ACO to steer beneficiaries to their partner providers and other that they choose to designate as within their network. It would also provide a role in ACOs for physicians in many specialties, even if they are not partners who are sharing savings or losses. Now this will need additional changes in how much medigap can supplement Medicare. I think what MACRA did is a useful start, but there is going to have to be a provision so that differences in coinsurance in network and out of network are not completely offset by the supplemental coverage.

As far as quality measurement and alignment across providers, I do support -- we do support the approach of using a quality threshold before shared savings are paid, but alignment in the measures is not there now. You know, in the past on many dimensions such as the physician relative value scale, coverage decisions, private carriers and Medicare programs have followed Medicare. This is not happening so far in ACOs where there all using their own quality measures. Presumably they're not finding the Medicare measures attractive enough to follow, but I am optimistic that the various discussions that are happening between carriers, CMS, and provider leaders under the sponsorship of AHIP might actually move us in that direction.

Ultimately we're going to need quality measures that are meaningful to beneficiaries including clinical dimensions as well as the patient experience. In particular we're going to need summary measures, whether they're star ratings or something else. I think there are opportunities to expand the range of services covered and it's particularly important to include post acute care in as many approaches as possible. The Institute of Medicine's Geographic Panel showed how most of the variation in Medicare spending geographically was based on variation in post acute care. So it's important to include this in as many bundles as possible. It's already in the ACOs. For bundles that have significant Part B drugs, certainly they should be included in the bundles and I'm pleased to say that the CMS recently announced an oncology bundle that includes both Part B and Part D drugs. I think there's a need for additional bundles outside of inpatient settings, but I believe CMS will need to customize many of them. Here are some of the characteristics of promising bundles -- and this comes from a Bipartisan Policy Center report published in January that I played a role in -- high volume episodes, episodes with substantial variation in spending from provider to provider, relatively small number of providers to coordinate with each other, presence of clear objective clinical guidelines that trigger the episode, and also treatments that are not especially supply sensitive.

So a few comments on the path forward, I do believe we need to mandate reform payment for specific services. This will allow it to apply to more beneficiaries, provide more beneficiaries care, generate greater federal savings, and resolve those very challenging benchmark issues that I discussed above. I think we need to broaden the incentives for providers to participate in reform payments, and I can envision applying the approach in MACRA, which was focused on physicians, to other provider types. There needs to be some work on the resolution when multiple payment approaches apply to the same beneficiary. And CMSs appropriately make sure that

savings are not shared twice, say by a bundled payment entity and by an ACO, but I'm concerned that the way in which they've done I could undermine ACOs. Basically it all goes to the bundled payment entity. And we want ACOs to get a portion of bundled payment savings for steering the patient to an efficient provider.

So in conclusion I think realizing the potential of payment reform would require improving the payment models. We really need to get wider provider participation. This will improve the outcomes of care and gain budget savings for more beneficiaries, and allow the movement away from provider specific historical benchmarks. And voluntary participation is just not a long-term strategy. So I can say just imagine what if we had pursued inpatient perspective payments as a voluntary program back in 1983? Can anyone imagine what it would be like today? The program probably would have crashed years ago.

Thank you very much. (Applause)

I'd like to turn next to our discussant, Mark McClellan.

MR. MCCLELLAN: Thanks, Paul. And I want to thank Paul and Gail for a very thoughtful overview and lots of recommendations on the next steps in this dynamic and also complex area, the very timely area of payment reform. This matters, it's getting a lot of attention. Paul mentioned the Secretary's priority on it. It's a major activity in very private insurance plan and the state level too. And obviously what Medicare does makes a big difference in what happens for the overall healthcare system's adoption of payment reform. So in the paper they review some of the key experience to date under Medicare payment reforms, including medical homes and bundled payments and ACOs. They note however that although these are promising many of them are early in implementation, have been subject to limited formal review. And so I think the words you used were any conclusions so far are tentative. The reforms as well have generally shown either not

results or modest savings. But nonetheless they urge continued steps to implement and refine these payment reforms. And indeed as you just heard Paul highlighting, encouraging the aim of mandatory not voluntary payment reforms. And they've got some specific suggestions for doing so.

What I want to talk about first is this raises the really good question of what are the right reforms and what should be the basis for proceeding on them to this level of stronger, mandated, potentially major changes in the way that healthcare payments work. And Paul talked about some of the things to look for in that respect. One approach might be observing what providers are saying, and in the absence of better evidence, relying on the take up of reforms by providers. And the persistence of providers in these payment reform programs is a very important consideration. Hospitals, physician groups, other healthcare organizations have been very actively engaged in Medicare payment reform process, and have expressed a number of frustrations with it. But there is a trade-off. For one thing, if you have too much early participation in payment reforms it may turn out to be a mistake if that reform doesn't pan out in terms of improvements and outcomes and reductions in costs. And as they pointed out there are some reasons for skepticism given some of these early models. For another, a way to get more participation is definitely to make the terms more favorable to providers, give them more money up front, reduce the financial exposure, risk of financial losses. But if you do those things, as the actuaries will tell you, it can be harder to make sure that the reforms really will drive transformations in care and reductions in costs. And the third point is that while I deeply appreciate the hard work of my former colleagues at CMS, what I think we've learned is that when you're undertaking some big major reforms, some substantial reforms in the way that payments work, it is very hard to get them completely right out of the gate. And for that reason it might be a good idea to limit participation until

experience and evidence is accumulated. And that kind of gradual roll out strategy is what many private payers are doing today with their payment reforms. They're aiming high but starting with a limited number of providers and then going up kind of gradually over time.

So I wanted to take these ideas and kind of apply them to some of the very recent experience with Medicare's payment reforms, particularly in the accountable care organization program since -- great timing for this event -- version 2.0 of the Medicare shared savings program was just announced by CMS yesterday afternoon. This revision to the ACO program was based on a proposed rule released late last year, and the experience of the program over the first couple of years that raises all of these points that we've just been discussing. Now we're still going through this regulation here, it just came out, but the new revised framework acknowledges and begins to address a lot of the suggestions raised in the paper. These include a commitment to transition from provider specific benchmarks, which is pretty much what you have to use at the start of a voluntary program, to a benchmark system that's based on something like regional cost. And it recognizes the importance of rewarding high performers as well as improvement. It includes prospective attribution of beneficiaries, and beneficiary attestation to the organizations that they're in for the ACOs that are moving farther down the road to major payment reform, including taking on so-called downside financial risks, the more substantial payment reforms that Paul and Gail have highlighted as being potentially desirable if they work. CMS understandably focuses the most substantial reforms in these areas where there is the biggest movement away from fee for service and has announced recently some further pilots in the next generation ACO program, like opportunities for beneficiaries to share in cost savings for using providers that are part of this payment reform program, opportunities for ACOs to share savings with specialists

and other physicians who aren't formally members of the ACO, but who treat the ACO patients. So there are some steps moving in this direction.

I also wanted to highlight a couple of other things that CMS has listened to providers on. One is the very important issue of effective data sharing so that you'll reduce the uncertainty about how you'll do in these programs. Also some issues related to risk adjustment and the like. So there is this kind of iterative process going on. Second, CMS made very clear in this regulation that they were trying hard to make the program revisions based on the evidence. So as you heard from Paul the evidence so far in the Medicare ACO program could be regarded as modest. And the first year or two, I'm guessing first two years of the pioneer ACO program, counting the ACOs that subsequently dropped out, they got savings estimated on the order of \$300 per beneficiary. Maybe that's modest. A subset of these ACOs have done much better and more of them have done much better than would be observed by chance, which again maybe makes you think that the program shouldn't be adopted by everyone, or that there are some ways of reducing uncertainty about how organizations can actually succeed in these bigger payment reforms. In any case this evidence of savings was regarded by the CMS actuaries as substantial enough to lead to an actuarial certification that expanding the pioneer like program would significantly reduce Medicare program costs, and in turn this was a basis for incorporating, or at least part of the basis, for incorporating the significantly revised version of the pioneer program as a full part of Medicare now, or at least when the final rule takes effect. So when provider acceptance is one important consideration for broad acceptance, that's absolutely right, so is generating the best possible evidence. And what we need is better ways to do both more efficiently and faster. And I think there are some good ideas for that. We've talked and written about the better, faster evaluation methods elsewhere.

I would also highlight the important recommendation of alignment in payment reform across providers. That's a very good idea. It's hard to see how healthcare providers can sustain big improvements in care if different payers are pulling the healthcare organizations in lots of different directions. In the paper the focus is on quality measure alignment. I just want to emphasize that it's important in other areas too. The types of payment reform models adopted, the attribution and benchmarking methods, the data sharing methods, lots of things beyond quality. And the main recommendation in the paper, I think, is that Medicare maybe shouldn't lead the way with private payers following, but there should be a collaborative process even though, Paul, you highlighted Medicare leading the way in the past. And I think that it is true that in the past private payers have sometimes followed Medicare in these previous payment reforms, I'm not sure that's going to be the case here. For example, in moving towards real risk sharing models like the Blue Cross of Massachusetts alternative quality contract, the private payers are actually leading the way. They're doing kind of bigger, more substantial reforms than CMS has been able to do so far on a large scale. So I appreciate their highlighting a different approach, one that involved more public-private collaboration in getting from there to there in this complex process; and that is the main focus of the recently announced Healthcare Payment Learning and Action Network, to try to take up that challenge.

And then just before I wrap up a few words about bundled payment reforms which were a big part of the focus in this paper. Once again I urge trying to find way to make sure that we're balancing participation and rapid adoption with more efficient and better evidenced development. This has turned out to be a bit challenging for bundles that go beyond discreet elective procedures like bypass surgeries or joint replacements. I think that one of the most popular bundles in Medicare's bundle payment

for care initiative, one that's mentioned in the paper, is congestive heart failure which is an area where there is certainly room for improvement in care, but if you look at some of the best practices in this area the best care is that kind that doesn't result in nearly as many admissions to the hospital for this condition, this chronic condition in the first place. So just focusing on, as Medicare has done so far, on hospital based procedures is only going to take you so far. And for chronic diseases like heart failure, that especially in the Medicare population usually go along with other chronic diseases like diabetes, kidney disease, other conditions, it can be hard to separate out a specific bundle. And so maybe a more comprehensive medical home payment with accountability for overall costs and outcomes might be better. That's what a number of private insurers are doing now. In fact the fastest growing group of ACOs in the country, both in Medicare and in the private sector, are those that consist mainly or entirely of primary care physicians supported by care teams who are starting to take on overall cost and outcome accountability for patients like these and working selectively with specialists and hospitals when needed.

So a lot of good stuff here. I do want to come back the authors with one question since we're talking about Medicare 2030, is what do you think payment should look like 15 years from now? I know the complexity of this area and the need for better evidence on what really works makes that hard to address. We took a stab at this in a report that we did last year -- in 2013 on bending the curve in healthcare. It featured ACOs with payments that are much farther in the direction than we have today towards partial capitation, with benchmarks tied to overall growth in the economy, coupled with payment models that work well for small, less integrated groups like primary care groups or oncology groups taking on significant risk for -- at the patient level and collaborating with other specialists through payment reforms that help them fit together. But this is an area that I think is unsettled and the more that we are able to develop a clear vision about

where we're headed I think really will help with focusing the implementation of effective, well coordinated pilot programs that can hopefully turn into real impacts on care.

Thank you all very much. (Applause)

MS. WILENSKY: I wasn't quite sure what the role of co-author was in this kind of a panel, so I'm going to just emphasize three or four points that Paul made in summarizing our paper and that Mark has alluded to as to what I think the issues are most important as we've identified.

The first is to recognize how much change is going on right now. We have to be careful as Mark said that we not get so much change that we aren't able to document what is driving the observed changes. And also because we want to be careful not to overload the system, either in terms of the administration implementation part or in terms of not being able to understand the kinds of effects that are resulting.

We thought this question that we posed about should we think about ACOs and some of the other pilots as necessarily on the road to Medicare Advantage as one that needs to get more attention than is sometimes given. There are some opportunities that are very difficult to achieve if you do not have a fully at risk plan. And we can talk about some of the differences that go on if you have a full risk ACO versus a Medicare Advantage other than the fact of the insurance function per se and how much effect that has, and other than whether or not you have patient engagement which is now not so obvious or easy in a full risk ACO, but might become different over time. And at that point is there actually very much difference between those two models and does it matter. So that will be question. When you were describing your thoughts about where we might be in 2013 [sic], parsing out how that differs from well functioning Medicare Advantage plans becomes interesting. Not that there aren't any differences, but there might be much smaller differences than we traditionally have thought about when we

have these two models.

The other real question that we have raised had to do with, as Paul mentioned, this voluntary nature and the trade-off between jumping too fast to enforcing a particular innovation and realizing that some changes are so much more difficult to implement if they are on a voluntary nature, the benchmarking being one that we reference in the paper. Although we did see what is in the MACRA legislation as an interesting alternative to not requiring mandatory adoption of a particular innovation, which is to say that providers could have a choice of being in one of a limited specified number of alternative delivery systems that presumably have been shown to improve value, or to meet a set of metrics that would reflect both clinical outcome improvements and better value for the beneficiary while still in a fee for service world, or face a much less pleasant financial environment that is either no updates or in fact even negative updates, that is getting dinged for those kind of metrics. And that is somewhat different than what we have traditionally done in Medicare and that that's really one of the most challenging questions.

The other is, and we hear this all the time in healthcare, the devil is in the details. Well, this really becomes an issue here because you need to specify which of the metrics are going to determine whether or not somebody that is providing services to Medicare in traditional fee for service should qualify them for receiving a bonus. We wanted to press the point, let's not forget those that are important to the beneficiary in addition to more traditional clinical outcome and/or process kind of measures. But also which of these alternative delivery systems ought to automatically qualify for a bonus, because we've been impressed that what we've seen to date while in concept promising, in practice has been -- I'll use the modest, shall we say, but pretty darn modest indeed, and especially when done by independent evaluation.

The good news is that what might have been the response of CMS or the provider community is throw all of this out and start over again in your thinking seems to be instead generally good ideas, we haven't figured out how to make them function better. And that's really where we are now. And so on that ground I think there really is some promise learning that pilots are tough and trying to figure out which work and which don't and move on, getting evaluations, and not doing it so quickly that we get lost in the middle, but not letting it drag on so long that we actually do imagine a world post 1983 where DRGs are still voluntary. (Laughter)

Let me start here. (Applause)

MR. GINSBURG: Just one thought responding to things that Mark and Gail said about 2013 [sic], I think in many --

MR. MCCLELLAN: 2030 or?

MR. GINSBURG: 2030, that's right. (Laughter) I think in Medicare, I think that non fee for service payment will be very important in 2030. What is hard to see now is whether it's predominantly ACOs or predominantly a combination of bundled payments and an advanced medical home idea where the primary care physicians are at some risk for global spending by beneficiaries attributed to them.

The other point I want to make is that it's likely that we're going to see a lot of parallelism between what Medicare Advantage plans do to pay providers in their plans and what traditional Medicare -- you know, when we talk about alignment of methods used by insurers, some of those insurers are Medicare Advantage insurers. So we can think down the road about what will be the strengths of Medicare Advantage plans versus traditional Medicare if they're both heavily using these approaches to pay their providers.

I'd like to have some questions. Yes, there's someone over there.

MR. MARDER: Bill Marder from Truven Health. This is maybe the guy with a hammer looking for nails, but we're living in a world of diverse reimbursement regimes, for years, going on into the future. It would be nice to have a consistent measure of what's happening across those reimbursement regimes and encounter data could do that. A face to face encounter between a provider and a patient is going to happen in all of those reimbursement regimes. And we've had Part C for a long time with very limited encounter data. So the question for two former administrators, why don't we get more detailed information from our managed care plans so that we can actually look at what happens inside the black box?

MS. WILENSKY: Well, the practical reason is a very simple one which is that to date they don't have to report on an encounter basis in order to get paid unlike fee for service where if you don't have reportable, documentable encounters you won't get paid, and if you do get paid you'll get challenged. So it would have to be a specific requirement that you provide encounter data. That is unlikely to be viewed in a friendly way unless there is payment for that kind of reporting the way we did for hospital quality metrics. But I think you need to be careful about what would be reasonable to ask for and whether we want to focus -- I mean encounter data sounds an awful lot like focusing on inputs when we keep trying to move to a focus on outcomes and appropriate clinical measures. And we would have to be very careful that this does not end up in a requirement of doing things in a fee for service mindset that is basically the opposite of what you want to encourage in a Medicare Advantage program where if you're doing it well you could have good integrated care, coordinated care for treating chronic diseases. So you are correct that the ability to understand what is going on during visits is becoming increasingly challenging as more and more people are in Medicare Advantage and traditionally there has just not been very good data on that basis. We need to make

sure what we ask for is not framed within the fee for service mindset.

MR. MCCLELLAN: You're more my fellow former administrator, more former administrator, I mean, but where the emphasis seems to be going, including in that collaborative plan -- Medicare -- hopefully broader process soon on performance reporting is towards more clinical measures, more outcome oriented measures which in principal could be based on encounter data, but are much more things like hemoglobin A1C levels, patient reported functional outcomes, I think in some cases use of evidence based approaches to clinical care. I mean that's where the main thrust seems to be because exactly what you said, it's tied to what these payment reform -- more directly tied to what these payment reforms are intending to support, not something that's more about utilization.

(Audio interruption)

MR. MCCLELLAN: Consistency would be -- yeah, I'll agree with that.

MS. WILENSKY: Well, that would necessarily -- but you ought to ask is why don't we push the fee for service world to be much more focused on outcomes the way we have in terms of what we now call Medicare Advantage. I mean we're going to get the input measures as long as we pay on an input basis. What we haven't done, especially in ambulatory care, and what I think is a completely shameful way for traditional Medicare, is insist on the same kind of outcome measures, crude and elementary as they sometimes are, in the traditional model that we have in the at risk model. And that's been true basically for the last two decades.

MR. GINSBURG: There's a question there.

MS. RUCKER: Lee Rucker, independent policy consultant. My firm is called Enhance Value. Having read these papers in reverse order -- I was fortunate to start with this one and was very energized. I particularly appreciate the references on the

patient engagement and also quality. My question goes to perhaps the opportunities in these alternative payment models for potentially multi-year budgeting if you will, or multi-year incentivizing of patients. Might there be opportunities that if a beneficiary agreed to stick to a particular ACO, if you will, for maybe a three year period or something, would there be particular shared savings or some sort of reduced payment? So I'm thinking particularly in much of my work has been in the pharmaceutical policy arena. Greg Daniel referenced earlier with the new Hep C drugs the frustration on insurers that if they pay for the drug up front the long-term benefits accrue to the patient by the time that they have moved on to another plan. In Australia pharmacists have five year agreements with the government to be compensated for pharmaceutical care services beyond just the dispensing. So I just wondered if there might be considerations along that line? Thank you.

MR. GINSBURG: I would think that it's -- actually we have so far to go just to establish beneficiaries designating that a primary care physician is theirs or an ACO that -- in a sense I think it would be much harder to get the political system to move that way if it were for a multi-year period. So maybe in 2030 might be a time to go there. (Laughter)

MS. WILENSKY: Come back and ask the question -- 2030.

MS. RUCKER: Thank you.

MR. MCCLELLAN: You can get -- as you mentioned there are -- you know, many of these contracts they have payment reforms, they have elements that go beyond one year. You mentioned Australia having the five year -- I mean that's what the provider -- in the Medicare ACO first round program has a three year contract. This new revision envisions kind of a longer-term pathway than that potentially. Utah has recently implemented some accountable care ACOs through managed care organization reform

for they made a commitment not to rebase the budget off savings for years to come. We'll see if that state can stick with that. But it does help provide for a longer-term focus. I mean what's really going to get outcomes improved and costs down, and those strong relationships with patients can be a critical part of that. So even though you may not get to, you know, like a three or what would be perceived as a three or five year patient lock in, I think some of these kinds of programs and payment reforms and reforms on the benefit side could help support that.

MS. WILENSKY: There's no question you could look to invoke strategies that have medium-term payoffs, not necessarily really long-term payoffs, if you could get an agreement for other than a year or even a year or two. But we're going to have to wait on that. It's just -- it's very hard. We are still grappling to figure out which of these kinds of payment reforms seems like it really has legs and will go successfully into the future. But it is an important issue.

MR. GINSBURG: Let me hand off to Dana Goldman.

MR. GOLDMAN: Great. Thank you to the panel. Thank you everyone. (Applause) If Bob Reischauer is correct it's 10 percent about the policy and 90 percent about implementation. We got the 10 percent here, so we'll let you continue. Thank you very much.

MS. WILENSKY: Thanks, Mark; good ideas. (Applause)

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