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Medicare, Beneficiaries, and the Deficit Reduction Debate
Kaiser Family Foundation
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TRICIA NEUMAN: Good morning and welcome to the Barbara Jordan Conference Center here at the Kaiser Family Foundation. I am Tricia Neuman, a Senior Vice President at the Foundation and I'm Executive Director of our program on Medicare policy. We are here today to talk about Medicare just in case you want to be sure you're in the right room.

People who are covered by Medicare, and Medicare's role in deficit and debt reduction discussions. We are really pleased this morning to have Bruce Vladeck and Gail Wilensky who will be with us in a little while to offer their perspectives on the Medicare debate as it's currently being framed. We'll get back to them in a little while.

It's almost hard to believe that just a little bit more than a year ago, there was a great deal of debate about the Medicare savings in the health reform law as you may remember but here we are, a year later, and once again we are talking about Medicare savings but this time in the context of deficit and debt reduction. Medicare savings are back on the table, as you can see here, because Medicare is growing as a share of the economy, that's on the left side, as a share of GDP.

Also Medicare accounts for a relatively large share of the federal budget and it's growing as a share of the federal budget. So as you can see now, Medicare is at about 15-percent of the federal budget and when conversations start to focus on

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reducing federal spending and reducing the federal budget, they invariably turn back to Medicare.

As the administration and Congress edge closer to a vote in raising the debt limit and as policy makers continue to discuss policy options to reduce spending, it's not entirely clear to me, to us what specific proposals they're talking about or what might be on the table. It's not entirely clear what the magnitude of savings are likely to be.

Well what is clear, as you can see in this exhibit, is that virtually every proposal that has focused on deficit and debt reduction, have talked about Medicare savings in some form and of some magnitude. This is sort of a cheat sheet, if you will, but it shows you the nature of different types of proposals that are under discussion, some broad, some narrow, but what you can see is a couple of things. One is several options are on the table and two, there's a good bit of disagreement about which options should be given serious consideration.

While there is some potential for agreement on the general concept of Medicare savings as part of debt reduction, it's quite clear that it's going to be a bit of a heavy lift to come to agreement and to determine which of the proposals are under discussion. That's for a couple of reasons.

First, Medicare is very popular among seniors who vote. I think that's no surprise to everyone in this room. Medicare

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provides coverage to people without regard to their income, without regard to their medical history, and that's pretty important to people in Medicare who tend to get sicker as they get older. .So medical insurance is guaranteed to them without regard to their health conditions really matter. I think many of you in the room know that about half of all seniors lacked health insurance before Medicare was enacted.

So today, we almost take it for granted that seniors can get health insurance when they turn but this thing about taking Medicare for granted shakes a little bit loose when seniors are confronted with the very real prospect of losing this coverage. So that's the first reason why I think coming to consensus on significant Medicare savings may be difficult.

The second reason is that even with the benefits that people get from Medicare today, many people on Medicare have considerable skin in the game. Now we have been looking at out-of-pocket spending as a share of income for quite some time. What we have documented and you can see this in the materials in your folder is that over the years that the share of income devoted to health care spending has continued to tick up and it's pretty straightforward.

It's because health care spending is rising more rapidly than income. The concern here is that some people on Medicare really do pay a great deal. As you can see in this exhibit, many beneficiaries are spending a large share of their

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income. In fact, one in four people on Medicare spend 30-percent or more of their incomes on health care in 2006. So asking people on Medicare to pay more is going to be a concern at least for some who are already paying a great deal.

As you can see in this exhibit, people on Medicare have a greater health care burden than non-Medicare households. This is in terms of absolute dollars and is a share of their household budgets. Health care accounts for 15-percent of household budgets for people on Medicare versus five-percent for non-Medicare households. So when you hear that people on Medicare aren't paying enough or don't have a health care burden, I think the facts may tell a different story.

A third reason why the search for savings could be quite a challenge is because of the significant savings that were recently enacted in the health reform bill turning back to where I started a few minutes ago. There were significant savings, the net of, had a little bit more than $400 billion in savings over a 10-year period.

As a result of these provisions, which you can see here and if you focus on the orange bars for a second, Medicare spending, if you look at the period between 2010 and 2019, on a per capita basis is projected to grow quite slowly relative to the economy even when you adjust for physician fees, which we use the shorthand of SGR.

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If you compare Medicare per capita spending to what it was in previous years, the group of bars on the left side, you can see that due to the health reform law in large part, Medicare will grow far more slowly in the next several years than it has in the past on a per capita basis. The fact that Medicare has such low projected per capita spending growth means that it will be that much harder for negotiators to find what some are calling the low hanging fruit.

So in a few minutes, we will turn to Bruce Vladeck and Gail Wilensky to offer their perspectives on this low hanging fruit and what policy options are likely to be considered but before we get to that, it would not be a Kaiser event if we didn’t have a few more wonky slides and if we didn’t focus on the people who are deeply affected by the prospects of this debate. So we are going to begin this morning with Dr. Gretchen Jacobson, who is a principle policy analyst here at the Kaiser Family Foundation.

She’s going to be presenting results from a study that she did in conjunction with Karen Smith, who’s here, from The Urban Institute, that looked at two questions that are quite important, we think, when we start to talk about policies that would shift costs on to people on Medicare.

First, how affluent are people on Medicare today? What do we know about their income and their savings? Second, will Medicare beneficiaries, in the future, will the next generation

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of people on Medicare, have significantly greater capacity to absorb rising costs. So with that, I'm going to turn it to Gretchen to help answer those questions.

GRETCHEN JACOBSON: Good morning. So today, I'll present a brief overview of some of the work that we have done that examines the income and assets of current and future Medicare beneficiaries. This work was done in conjunction with Karen Smith of The Urban Institute and is summarized in a spotlight in your folder.

The data I will present is from a microsimulation model of people's financial experience over their lifetimes. Our questions were how much money do people on Medicare currently have and what is the outlook for the next generation of Medicare beneficiaries, those who are currently in their 40s, 50s, and early 60s.

Most people on Medicare have less than $22,000 in income in 2010, as you can see here by the red bar on the left. There is wide variation in the incomes across subgroups of people on Medicare. You can see here in the yellow bars that most White beneficiaries have higher incomes than most Black and Hispanic beneficiaries.

Also the disabled people on Medicare who are younger than 65 and the people who are 85 or older also tend to have lower incomes as shown in the green bars. Most of the people ages 65 to 74, the wealthiest age group, had incomes below

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$27,000 in 2010. You can also see that single and widowed Medicare beneficiaries had much lower incomes than Medicare beneficiaries who are married. Most of them had incomes below $26,000 per year per individual.

So as Tricia said, this research really gets at the core question. How affluent are the elderly? So we began by examining the distribution of income among people on Medicare and found it to be very skewed. As you saw earlier, half of all people on Medicare had incomes below $22,000 in 2010 and 25-percent had less than $13,000 in income. However, when we look at the other end of the distribution, we find that five-percent had more than $87,000 in income. One in 100 had more than $150,000 in income in 2010.

So we then looked at how much do people have to draw on savings either in a retirement account such as an IRA or other financial assets such as savings, stocks, or bonds. In other words, how much do they have in their retirement nest eggs. The vast majority of people on Medicare had about 91-percent of them had some savings. However, just as we saw with the income, the distribution of savings among beneficiaries is skewed.

Half of all people on Medicare have less than $53,000 in savings in 2010, which is less than the cost of when you're in a nursing home and 25-percent of people on Medicare had less than $8,400 in savings. However, on the other end of the

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distribution, 10-percent had more than $570,000 in savings. Five-percent of people had more than $1 million in savings.

So lastly, we looked at the extent to which people on Medicare could draw on the equity in their homes to cover their other expenses. Nearly one-quarter of people on Medicare did not have equity in their homes in 2010. Like we saw with income and savings, the distribution of home equity among people on Medicare is also very skewed.

Half of all people on Medicare had less than $61,000 in equity in their homes in 2010. As you see here, nearly one-quarter of people on Medicare did not have any home equity to draw upon. However on the other end of the distribution, 10-percent had more than $250,000 in home equity. Five-percent had more than $350,000 in home equity in 2010.

So given the current policy discussions that would affect future Medicare beneficiaries, we wanted to know whether the next generation of Medicare beneficiaries, who are currently in their 40s, 50s, and early 60s, will be wealthier than current Medicare beneficiaries. We found that incomes will be slightly higher among the next generation of Medicare beneficiaries. These numbers are adjusted for inflation.

Half of all people on Medicare will have less than $27,000 in 2030 up from $22,000 in 2010. Yet when we look at the change in income stratified by percentiles, we can see that

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there's more growth in the upper income groups than among the lower income groups.

Income is also projected to grow more among Whites than Blacks and Hispanics and projected to grow more among the higher educated subgroups. We saw similar patterns in the growth of savings and home equity with somewhat greater savings in home equity in 2030 than in 2010. Yet much of this growth in assets is projected to be concentrated among a minority of Medicare beneficiaries leading to a wider gap in assets among the next generation of Medicare beneficiaries.

So in summary, most people on Medicare have modest means with limited incomes, limited savings, and limited home equity. There are some people on Medicare with higher incomes and assets but they account for a relatively small share of the population.

Looking to the future, incomes and assets are projected to be somewhat greater but the growth is projected to be concentrated among a small subset of the population who are disproportionately White and college-educated beneficiaries. This analysis helps to paint a picture of the financial well being of Medicare beneficiaries and how the next generation will fare as policy makers look for ways to slow the growth on Medicare spending and help to lower the national debt and reduce federal spending. Thank you [applause].

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TRICIA NEUMAN: Thank you Gretchen. Now to help us understand what these numbers really mean for people, I'm going to turn it over to Juliette Cubanski who is Associate Director of the program on Medicare policy and co-author of a report that's in your folder and Juliette if you could come up.

JULIETTE CUBANSKI: Good morning. As Tricia said, this wouldn't be a true Kaiser event on Medicare if, in the midst of our lovely slides and data, we didn't take some time to focus a bit on the people who benefit from the valuable, financial, and health protections provided by the Medicare program. So earlier this year, Kaiser embarked on a project to interview 16 Medicare beneficiary families in and around three metropolitan areas across the country here in Washington, D.C, in Detroit, Michigan, and in the Los Angeles area.

We wanted to learn about the financial challenges facing these beneficiaries in managing their household spending on relatively limited incomes as well as the extent to which they faced burdensome health care costs. We interviewed both married couples and single individuals or in some cases their caregivers, people with an array of health conditions, incomes, and financial circumstances.

None are very wealthy and none are impoverished but some only get by with help from family members or they rely on credit cards. Few have significant savings or retirement accounts to draw upon. Most of those we interviewed do not

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qualify for any extra help for the government in paying for their health care costs or their other basic needs.

The project had two outcomes. The first is a report called "Living Close to the Edge," which is included in your packets, which provides detailed profiles of the 16 beneficiaries we interviewed. The second is a video produced by Kaiser's own Jackie Judd that you are about to see for its premiere showing here this morning. Jackie spent time with three of the families from our interview project and has woven their stories together into one compelling piece.

As the report documents but as Jackie's video really brings to life, these are people on Medicare who are, for the most part, just getting by and worried about making ends meet for the rest of their lives and who could be greatly affected by the outcome of the federal deficit reduction debate that we are here to hear more about this morning. So with that, I am extremely pleased to introduce "Making Ends Meet: The Medicare Generation."

[Video Played]

TRICIA NEUMAN: Thank you Jackie. Thank you Priscilla. Thank you Georgia and thank you Darlene and Robert. We are now going to turn to what might be the funner part of our program [laughter] just to be honest. We are so happy to have with us Bruce Vladeck and Gail Wilensky. I think it's fair to say that we have two national Medicare treasures with us both with

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unmatched expertise and what you might call the three P's of Medicare.

They're looking at me like what would that be, programmatic management. They have both been administrators of what we now call the Centers for Medicare and Medicaid Services back in the day called HCFA and to be the administrator of HCFA or CMS, you have to understand how to manage the program and deal with the nitty gritty challenges.

They are also quite expert in the policy issues facing Medicare, which is what we're going to talk a great deal about today. I think it is also fair to say that they have also paid their dues in the politics of Medicare. So we are really, really thrilled to have them.

Dr. Gail Wilensky is an economist. She is a Senior Fellow at Project Hope. She served as Administrator of the Health Care Financing Administration under the first President Bush between 1990 and 1992. During her tenure, she dealt with many of the issues that are still around us today and she testifies frequently. She is called upon often for her expert advice. She was Chair of MedPac for several years. She is clearly a Medicare expert. We are so happy to have you here.

Bruce followed Gail to the Health Care Financing Administration where he served under President Clinton. After his stint at HCFA he went on to spend some time working with a national bipartisan commission on the future of Medicare where

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he also dealt with many of the issues such as premium support that we're talking about today.

Currently, Bruce is a Senior Advisor to Nexera, which is a consulting subsidiary to the Greater New York Hospital Association. He's also Chair of the Medicare Rights Center Board and we are very, very happy to have him with us. So we have two highly regarded Medicare experts with us. So now, I'm going to switch to my more Oprah position to engage in a little bit of a discussion.

GAIL WILENSKY: These chairs need to come with footstools for us short people [laughter].

TRICIA NEUMAN: Exactly. So the way this is going to work, I'm going to start and ask some questions and then after a while, I hope you will raise your questions. I'm going to give you some time to think through what you want to ask. I'm going to start, well actually first I'm going to give you each a chance to kind of make a few opening comments. There's been a lot in the news about Medicare and I'm wondering if you have thoughts that you'd want to just put on the table to get going. Why don't we start, Gail do you want to start?

GAIL WILENSKY: Sure and thank you Tricia also for warning me not to wear a skirt today. I appreciate that [laughter] seeing the problems that have resulted.

TRICIA NEUMAN: We have to take care of each other [laughter].

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GAIL WILENSKY: I want to make a couple of points that seem to get lost in the cracks in all the discussion that's going on, which has a lot of heat. The first is that the notion of trying to stabilize Medicare for the long-term far precedes our current economic recession.

I think it's really important, most of the people in the room probably know that, those of us up here have certainly had many debates and discussions about the long-term financial liability of Medicare and that's really when I talk about issues in Medicare, I want to focus on the kinds of issues that I think are important in order to get long-term sustainability for a program that has had serious challenges for the last couple of decades.

First and foremost because historically, spending has grown substantially faster than the economy and secondarily is exacerbated by the shifting demographics that's going to roughly double the population on Medicare by the time the Baby Boomers finish retiring, as people know, the first of the official Baby Boomers started to retire in January of this year.

It will go on for 20 years. When we end up, we will roughly double, not quite, but almost double the population on Medicare but that's not the most serious problem. I think we could deal with that increase in the population. It is how to

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get a growth rate in Medicare that is sustainable. So that's the first point.

The second point is as part of the Affordable Care Act, which has many aspects that I support particularly the expansion of coverage, but many other aspects that have caused me great distress, which is the lack of reforming the delivery system. The Affordable Care Act has already impacted Medicare to the extent that it is actually carried out in a major way for the next decade mainly by reducing payments in a pretty significant way.

I raise the issue about whether it'll be carried out because as most of you know Rick Foster, the CMS actuary, has repeatedly questioned whether the out years in the payment reductions are likely to occur because of access problems that are going to rise, be believes, because there has not really been change in the dynamics and the incentives in the program.

The third point that I want to make is that there is some discussion but not very open clear discussion about the notion of whether or not we are proposing to change Medicare in a significant way and my response would be we actually left over that discussion without seeming to involve the American public very much in that discussion. That is Medicare has traditionally been an open-ended entitlement where we spend what we spend according to how people respond.

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Part B of Medicare, the physician payment, had the mechanism to not do that because it had tied the rate of the increase in the update to what happened in total spending that, as you all know, we've never actually used that mechanism other than in 2002 when payments were reduced by four-and-a-half-percent but now and not in a very explicit way, the Democrats in a much more explicit way the Republicans have embraced the concept of limiting spending on Medicare.

Congressman Ryan made clear in his discussion, his proposal, I'll be glad to talk about that later, about the rate of growth at CPI, I think that's too stringent, unreasonable. We don't have to redo the sustainable growth rate experience.

We know what happens when we put in law an unrealistic rate of increase but he clearly put that out there but the fact is the Democrats have, as well, people just didn't seem to realize, baked into the Affordable Care Act, are assumptions about total spending to be imposed by the Independent Payment Advisory Board if they don't happen, which they won't happen in my view because of the other changes that are in place and President Obama has actually upped the ante a bit in his proposals of saying we should keep Medicare spending growing at no more than .75 of one-percent of GDP.

So what has happened is that both parties have just embraced this very different concept of Medicare without really talking about if we were going to limit spending how should we

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do so and as a policy person, that's of course what I want to jump in and say, we can do it this way. The Democrats have proposed a limiting reimbursement on providers of Medicare or we can try to change the dynamics, which is how I would describe the move toward premium support, a modified Ryan plan, federal employees' health model, however you want to say that.

BRUCE VLADECK: Don't keep saying federal employees' health model as having anything to do with the Ryan plan Gail. That is just one of those sound bytes that distorts the debate. I'm sorry. It's just not at all like it.

GAIL WILENSKY: Well we can discuss that. I will say what it's different and why it isn't. It is certainly not exactly like it. The question of whether, I mean it's what you think are the characteristics of what you think are important of that or a premium support plan but anyway as I said and as I've written, clearly I don't support what Congressman Ryan has proposed as it is written. I support what I would regard as a modified Ryan plan and you could decide what those modifications, whether you think that is an FEHB-like program or not.

I do not support the Ryan plan as it was stated but I do support what I think is something in the spirit of the Ryan plan as opposed to what is being pursued currently and again, people can decide whether the nomenclature suits them or not.

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TRICIA NEUMAN: Okay, we'll come back to some of the specifics here. Bruce, do you want to make some general comments?

BRUCE VLADECK: Yes, I just want to make three points relatively briefly. First, I couldn't agree more that the long-term threat to the well being of the Medicare program arises from the rate of growth and cost but I would be a little more specific than that. The most serious long-term threat to the well being of Medicare program has been the inability, to date, of the private sector to control private sector costs.

There is a bit of movement in that direction, people hope, in the Affordable Care Act but if private sector costs, Medicare's already growing more slowly than private sector costs and will be throughout the 10-year budget window of the Affordable Care as Tricia's slide showed.

The problem is if private and it's been our problem for the last two decades, if private sector costs continue to grow at rates nearly as quickly as they have, Medicare essentially has two choices and is always walking the tightrope between sort of keeping up in a way that causes long-term enormous financial consequences negative for the program or of tolerating a growing gap between what Medicare pays and what private insurers pay or privately insured people pay since increasingly it's the insured out-of-pocket making those

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payments, which runs a serious risk of creating problems and access to physicians.

I think, on the hospital sector because Medicare beneficiaries are so large, a proportion of hospital in-patients, the effect is different but no less bad, if you get a substantially greater differential than now exists between what privately insured people pay and what Medicare pays, you put rural hospitals, many inner city institutions, many academic institutions, which are particularly reliant on Medicare in a very uncompetitive position in terms of maintaining the same level of service for their patients that hospitals in more affluent communities begin to have and that's true across a range of providers as well.

On the other hand, if we don't control private sector costs, we're in much worst trouble than just having to bail Medicare out again and again. That sort of has to be the key to any strategy in this regard. One of the frustrations in my professional activity over the last number of years, if you're talking about Medicare, you're not allowed to talk about cost containment more generally but we too, we need to do that for the well being of the Medicare program.

The second is to put the current Medicare crisis in perspective. I had the opportunity to testify at the Senate Finance Committee last week and I told the members of the committee that my principle reaction other than being pleased

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and honored to be there was an enormous sense of deja vous because I had sat at exactly the same table in 1996 and been confronted with all the talk of the unsustainability of Medicare and the budget crisis with the government and so on and so forth. In fact, we enacted the Balanced Budget Act.

In fact in the year 2000, we overdid it in the Balanced Budget Act because the CBO screwed up all the numbers but we were looking at a trillion dollars surplus in the federal budget in the year 2000. We were looking at 28 years in the expected future life of the Medicare Trust Fund.

Something has happened in the intervening decade that is causing this great financial crisis in the federal government and it's not anything having to do with Medicare. It's critical that we restore some degree of balance to the federal budget but I think we need to focus on what changed in the overall structure of the finances of the federal government in the last decade, which is mostly a fall in the proportion of the GDP that supports federal revenues from about 18-percent in 2000 to under 15-percent today. Frankly, I'm personally terrified that the current administration won't be insistent enough about addressing that problem as part of a long-term solution to the budget problems.

The third thing I would say and it's really very important is and I was thinking about the slide that was shown earlier about Medicare as a percent of GDP. This also has to

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do with the overall status of the Hospital Insurance Trust Fund, the overall state of the federal budget and so forth, and obviously Medicare's a percent of GDP as an arithmetic computation with two variables in it, one is Medicare spending, one is GDP.

It's remarkable what the impact is on the social insurance programs of economic growth. Anyone who thinks they can predict what the economy, the rate of growth in the economy's going to be three years from now let alone 75 years from now is a very, very effective salesman or [laughter] has a tie to another reality of the kind that I've never been able to identify.

The whole fact of the matter is that a critical part of all these projections and I mean between the 2010 trustees' report and the 2011 trustees' report of the hospital insurance Trust Fund, the expected remaining life of Medicare Trust Fund shrank by four years not from any change whatsoever in Medicare policy but because the economy has significantly underperformed the projections of a year ago especially in terms of employment since Part A is financed by a payroll tax.

So I think it's important as we talk about deficit reduction to really sort of keep our eyes on the ball and the ball is revenues of the federal government and economic growth.

The other reason that Medicare is a rising share of GDP is because we've basically stripped everything else out of the

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federal government expect defense and debt service and so there are many vitally important services and functions that the federal government used to pay for that it no longer does or no longer does to anywhere like the same extent.

Everyone's all abuzz at the moment about how we don't have enough physicians to meet the demand of an aging economy let alone of all the additional people that are going to have coverage under the Affordable Care Act at the same time that the federal financial support for health professions' education has almost disappeared from the federal budget.

So I think again in the context of a budget debate where Medicare is a contributor to the problem and where Medicare is a subject, an object of the problem needs to be made sufficiently clear and in the long-term, we're going to have to get a handle on all health care costs or we're all ruined whatever happens to Medicare in that instance.

TRICIA NEUMAN: Okay. Great, thank you. I'm going to now try to focus on some specific Medicare policy proposals that have come onboard and I don't think we can quite do this as I was thinking of speed dating where I'd ask a question, we'd have a rapid response because the concepts are pretty complicated but I would like to get your thoughts on some of the ideas that we've talked about or that have been talked about.

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One of them is raising the age of Medicare eligibility. That was mentioned in several of the proposals I think Senator Lieberman who may have an announcement coming out this afternoon has talked about that. We've taken a look at it here. What are your thoughts about raising the age of eligibility for Medicare?

GAIL WILENSKY: Well I support it but it will only give you so much and I support it with qualification. The first is people need to understand that the younger seniors do not spend as much as the average and certainly not as much as the people in their 80s and 90s. So you don't have an average Medicare savings but I think for many reasons that notion of moving the age of expected retirement out is appropriate. We have, over a very long time, done it with social security. I mean I think 70 is better than 67 and the question of how fast.

The qualification is that while most people in their mid-60s are able to continue working, there is an uptick in the number of people who cannot work because of disability and you clearly need to have allowances for people to become fully on Medicare if they are unable to continue working, full Medicare. So acknowledging that this is something that the last time I looked, the numbers were about 20-percent/22-percent in the 63, 65 range that are not able but that means basically that 80-some.

TRICIA NEUMAN: That's assuming health reform is implemented where people in their mid-60s could have access to coverage in the exchange and the subsidies. To some extent that particular worry could go away but are there other concerns you might have?

GAIL WILENSKY: Well I mean right now, people would say well where are we going to get all the jobs and the answer, as an economist, is I don't disagree with the point that a lot of these issues become different, look different when you have a robust economy.

There's a lot of debate about what it will take to get a robust economy and economists differ according to their own predilections and their political parties but the idea of saying oh we don't want to try to encourage people to be working out into their 70s because there are not enough jobs. Job sharing, as a forced idea, to try to share a finite number of jobs periodically comes up when you have recessions and depressions. It is a terrible idea. The right answer is no you got to figure out how to generate economic growth and jobs that will get you out of a lot of problems. So I do support it.

I think you have to have clear recognition that some people will not be able to work because of disability. You have to have fiscal policies that encourage that kind of activity and also have insurance available through exchanges or

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some kind of structure for the market. If we continue on employer-sponsored insurance, you might want to think about whether there's something you want to do to make it more attractive for the employers.

TRICIA NEUMAN: Bruce?

BRUCE VLADECK: Well I totally agree with Gail that it's very important in every way that we think of we can encourage people who are physically able to remain in the workforce longer. I mean if you really serious about 2030 year projections, you have to keep people in their late 60s or 70s in the workforce or the other thing, which causes great political, the only other way to have enough workers is to reopen immigration very broadly, which is okay with me too but not a very popular thing—

GAIL WILENSKY: Actually it is okay with me too.

BRUCE VLADECK: So I'm absolutely for it. I think assuming if the implementation of the ACA is stalled or significantly impeded then you'd have a real problem with people not becoming eligible for Medicare at 65, not only those who are disabled but essentially everyone over the age of 65 who's not employed in the absence of an exchange and a mechanism like it will be uninsurable.

Those are folks who are in the least desirable position to be uninsured but if you have an option, I think there's no reason not to do it. The only point to make out is that as a

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society, moving the eligibility age out so that people in their late 60s have private health insurance rather than Medicare may be a perfectly good thing on a number criteria but doesn't save us any money at all.

It's just an accounting device basically and as the estimates seem to be that it obviously saves Medicare money but most of those savings are counteracted by higher costs encountered by either the insured folks themselves and/or their employers. Now it may well be if the only thing you care about is the numbers in the federal budget that's perfectly okay but in terms of the economics of health care expenditures altogether, it really doesn't save any, net any significant amount of money.

TRICIA NEUMAN: Okay. I think I just have to ask about premium support. It's sort of the elephant in the room. I'm guessing that there's going to be a different point of view about premium support but I also feel that we ought to at least be clear about what we're talking about because there is the House plan, the Ryan proposal, which some people call premium support, others have called vouchers.

There is this issue that just emerged when you all were talking about is this idea really like the federal employees' health benefits program? Is it really like Part D, or is it not? What are some of the important differences, if there are?

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Gail, I know you've written about different ways you'd structure premium support.

I don't know whether I could even ask is there like is there any element of premium support that you would both agree is a good idea? So I thin I'm just going to ask you both to sort of give us your thoughts about the premium support debate whether or not you think it works, whether or not there are some issues in setting caps, per capita spending as the House bill would do, or whether you would structure it differently.

GAIL WILENSKY: Well I'm somebody who has advocated what I have labeled as a federal employees' health plan model for many years. Actually I was looking back, the very first article I wrote in *Health Affairs* in 1982 was commenting on Alan Entove's proposed plan, which I would regard as a premium support and federal health plan model-type program and the last line was altogether not a bad idea.

Alan Entove and I've been friends now for 30 years because he liked that I said that. So this is a longtime belief of mine and I will explain what I regard as the main characteristics but I won't argue that there are differences in various plans and you can call it whatever you like although probably not a voucher. I probably would not accept that.

The important elements are a variety of health plans that differ in a number of dimensions. To me, as I've suggested in a *New England Journal* article I wrote and I have

suggested previously when I proposed a Medicare reform with John Newhouse at the end of the 1990s, is that one of those plans be traditional Medicare. There is no reason that you can't view traditional Medicare on a premium basis. It is going to be out there anyway and for a lot of reasons that would give people comfort. So I would say a wide variety of private plans but no reason not to include traditional Medicare.

The fundamental concept that makes it a premium support or an FEHB-like plan is whatever the subsidy is, it's the same whichever plan is chosen. Now in the federal employees' health plan model, it is a fixed percentage. In a better model, that is, a stronger incented model, it's a fixed dollar subsidy that doesn't vary according to what plan somebody chooses from traditional Medicare to any of the plans that are allowed into the program. There have to be some rules of the game. Then the question is how do you set the amount? As people know, in the FEHB world. You look at the four most popular plans and 72-percent of the weighted average of that premium is what the subsidy is and that percentage continues on.

A better one is to do, again a stronger premium support is to have a fixed dollar amount rather than a percentage. The idea is how do you set that? With Congressman Ryan, it was estimated at what the federal dollar contribution would be in Medicare for 65-year-olds in 2022. What I think is important

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and have said this in the past is the amount that is set has to purchase something. So there has to be a third test on there that says if you initially start out that this is an amount, 80-percent, 90-percent of a plan in an area that you start, there's got to be at least a plan going forward in an area that meets that.

So you either can set the rate each year by some mechanism or you can have requirements that there has to be a plan available that meets whatever requirements that a subsidy covers, 80-percent or 90-percent of the cost of the plan in a market and if not, you need to revise the subsidy.

So for me, the really critical concepts are a variety of health care plans, private, but again I say in the Medicare population no reason not to have the Medicare plan. You have to have rules about what qualifies. The most important notion is that you have either a fixed dollar or a fixed percentage subsidy contribution that doesn't vary according to the plan that is chosen and that means that people who choose more expensive plans will pay that difference and people who choose less expensive plans will have even more of their plan covered than whatever is set as the expected share, again a lot of issues about regulations and how you implement that.

I think the notion of adjusting the amount so that sicker and poorer people get more money, which we've been gradually building into Medicare kind of in a sideways way we

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do things where we have the extra support for Part D and we have the Quimby slimby for people who are low-income but not low income enough to get Medicaid and then we have Medicaid, which was discussed in the paper yesterday, has the characteristic for the dual eligibles as being very expensive, very badly coordinated care. You could do a much better job if you provided a lot more support for low-income sick people. That's how I would describe it.

BRUCE VLADECK: Tricia, as part of your question, you asked if there are any things I liked about the FEHB model and I would say two. One is that the federal government would pay 72-percent of the cost of Medicare beneficiaries now encounter. We'd be way ahead. I mean it's now less than 50-percent on average. So that's an enormous boon and that would be appropriate I think. That's our model for health insurance.

The other thing I like about the FEHB plan is the notion of having a single federal official directly accountable to the President of the United State, negotiate on the terms and details and conditions and prices of the benchmark plans.

I think that would be an excellent idea. Apart from that though, the debate about premium support continues to astonish me because it shows how in certain areas of public policy discourse in this city and elsewhere the abstract faith and a theoretical notion trumps 25 years of very solid empirical evidence. We've been paying what we now call

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Medicare Advantage plans and Medicare Advantage was supposed to be designed very similar to what Gail described, that is let's make basically a fixed dollar amount available for private plans while keeping traditional Medicare in place.

We have 25 years' worth of experience where if you set a benchmark at the federal government's contribution, risk adjusted on average to the coverage of an average Medicare beneficiary, the private sector can't perform. They can't meet the basic benefit package. That's because they don't have the economies of scale of a national program and mostly because they have to pay for marketing and enrollment and stealing beneficiaries away from one another and network maintenance and all the other things that a single national program has enormous advantages in providing.

So I mean even in the midst of concerns about deficit reduction and so on and so forth and the biggest savings in Medicare achieved in the Affordable Care Act were an effort to bring the premiums that we're now paying on average to Medicare Advantage plans closer if not identical to the government's annual contribution to traditional fee-for-service Medicare and the house of complaint from rural Senators and Congressmen are ceaseless.

So the fact is we've been trying to move the Medicare program in this direction since TEFRA was enacted. At the moment we have a level of generosity in our payment of Medicare

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in the size of the voucher and the way in which we set the voucher that we probably will never be able to afford to achieve again.

Seventy-five-percent of beneficiaries are still in traditional Medicare. The plans have made it very clear that unless we pay them more than we pay for average fee-for-service Medicare, they're not going to participate. So give me a break. I mean I've been hearing these same arguments on how competition among private plans would bring down costs and empower consumers and we've been moving in that direction for 25 years and all the evidence is to the contrary that that'll work.

GAIL WILENSKY: We have not just done it. I mean the part that's—

BRUCE VLADECK: We never do it right. We never do it perfectly. After the fact, the economists always say if you'd only done this and plug this into here, then it would've been fine. So we keep trying and it keeps not working.

GAIL WILENSKY: It was in the 2003 legislation. I mean it's so frustrating. Exactly what I was proposing was in the 2003 Medicare Modernization. It said that in areas where there was at least 25-percent penetration of people in private plans and Medicare, starting in 2010, we should have, based on the world that I was describing traditional Medicare and private plans, they ought to be paid at the same level.

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Then let people choose. I don't understand if it's so obvious that people won't want to do this, why is there this constant fight against trying it? It was just an anathema then to say have these on the same grounds. It's like don't pay them more. I'm not arguing. I mean I argue, have for the last at least two decades, it's not the government's business whether somebody wants to take a private plan or traditional Medicare.

They ought to be structured so they're comparable. They ought to have comparable reporting requirements. Let people choose the plan that suits them best and if it's traditional Medicare that's fine with me. Don't distort it. Don't bias it. I don't understand why there is so much resistance against seeing this.

What I observed in the late 1990s when there was a huge push back against managed care, which by the way, had been very successful in terms of slowing spending on Medicare in the middle 1990s, the one place you didn't see it was in Washington and people who were part of the federal employees' health plan, which I attributed to the fact that every November people got to choose their health care plan and if they thought their insurance plan was not treating them appropriately giving them access to specialists or in any other way treating them as they wanted to, they could vote with their feet. That ability

relieves a lot of pressure. So why is there so much resistance against trying this?

BRUCE VLADECK: I don't think there's resistance against trying it. I think that's what we did in the Balanced Budget Act was we tried to move Medicare Advantage premiums up to a level equal to average fee-for-service costs.

GAIL WILENSKY: But never a direct, here we're going to pay a premium. Everybody plays by those rules, traditional Medicare on a premium basis and the private plans. Is that so difficult to say it will be just like one of the other plans in the offering and people will be able to see that? I mean that's really an important attribute as well.

This is the subsidy you're going to get, you, because of your age and your illness and your income, and here are the private plans or traditional Medicare that you can choose and here's the difference. Here are the benefits you get. Here's the difference you'll have to pay in premium. Here are the co-insurance, very much in the way that we see—

BRUCE VLADECK: Well among the reasons that didn't happen is because Congress would never permit traditional Medicare to have a marketing budget and to think that people can have free choice if you have the largest player in the field forbidden from conducting activities, which are protected under the first amendment by all its competitors already starts to give you a skewed kind of market.

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GAIL WILENSKY: Hard to see that the government doesn't play up Medicare, whichever party happens to be around but I mean that seems to me like a pretty flimsy reason not to adopt a strategy that, at least, brings in a lot more willingness maybe to consider putting constraints in place than you otherwise have.

If you have traditional Medicare as one of the plans there, it just seems to me you really diffuse a lot of the concerns that are otherwise gray. So as I've said, I just find it a mystery about why there's just not a willingness to try. I'm very frustrated because we would be already going into the second year of knowing what happens in selected markets if we had just—

BRUCE VLADECK: Let me just ask one question. Would you support offering traditional Medicare through the exchanges to people below the age of 65?

GAIL WILENSKY: Not until I try it first here. I mean that was why if we can't do it in Medicare where we already have them then I mean I want to try this here. We've already got this app, let it go here and then we'll see.

TRICIA NEUMAN: Alright I'm going to try to get a word in edgewise here. Actually what I want to do is invite you all to ask questions. So I'm going to try to ask one question why you all get organized. Raise your hand. There are people walking around the room with microphones and if anybody's

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ready, we can start now. Otherwise I have a lot of questions I haven't even started to ask. Help me out guys.

MIKE MILLER: Hi, Mike Miller. Bruce brought up a point about the private sector not controlling the costs to the same extent as Medicare. There's one part of the ACA that you guys didn't touch on and it's a little bit controversial now but it's the whole Medicare shared savings program, the growth of ACOs and that program is supposed to pull together Medicare and the private sectors, payers' interests, and it also can lead to something like, I don't know if we should call premium support but if you get towards capitation to the delivery systems, you're getting into a system that's not just fee-for-service. Is that a way to bridge the gap and to move forward in a way that people could agree upon if there's a Medicare in the delivery systems to make it work?

GAIL WILENSKY: Well I would phrase it differently but I'll try to respond to your question. For me one of the real problems of traditional Medicare has been it is a very fragmented, siloed system that is heavily fee-for-service-oriented and not very conducive to the coordinated care important for taking care of elderly people or people with chronic disease and that that has been a major problem along with the incentives of do more and more complex get paid more.

That is not a good set of incentives if you're trying to moderate spending. My frustration, in general, with the

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Affordable Care Act is most of the action, the legislative action has been on reducing payments to what I regard as a pretty dysfunctional delivery system that exists in Medicare with whatever changes are out there mostly embedded in the pilots has yet to be defined by the Innovation Center.

The accountable care organization was one of the legislated areas, which unfortunately, should've been a pilot in my view because we don't know what we're talking about yet. That attempt to allow for different incentives to exist allowing physicians across physician-type or physicians with hospitals to come together who are not formally integrated and to share savings if they are able to produce savings in a way that would violate the stark [misspelled?] and other existing laws if they were to do outside of the accountable care organization structure.

The idea, I've been dubious as to how successful it would be for two reasons, the first is it seems pretty tough to get this done even when you have enrollment models although Geisinger where now I am on the board and Kaiser, Intermountain Health Care certainly have a lot of suggestive evidence that they can do better.

So I was a little dubious about whether or not enrollment model would actually be able to work. We've seen now also proposed regulations, which seemed to say not be

engendering a lot of interest and support. So whether we'll actually see many of these form is less clear.

The idea's a good idea, which is to break away from the current really unhelpful incentives in traditional Medicare, get more income by doing more and more complex, not get rewarded or rewarded very little by either providing higher quality and particularly higher quality at lower cost unless you are in a capitated or Medicare Advantage plan where you can reach some of those benefits.

BRUCE VLADECK: Yes, I agree with much of what Gail's saying although again, the rhetoric and the inside the Belt Way way of talking about things really sort of makes me slightly crazy. She talks about how the Medicare system is sort of fragmented and there's no coordination of care. It's mostly fee-for-service.

That's the American health care system folks unless you live in California or Danville, Pennsylvania, that's the health system that you live in. in fact, 90-percent of the private managed care plans in the United States use a variant of the Medicare fee schedule, which Gail is in many ways is one of the real founding mothers of as the basis for how they pay physicians. Everybody bases on percent of Medicare on an RBRVS basis.

So the problem is that there's no disagreement that it would be a wonderful thing to significantly reform the delivery

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system in the United States in order to get better, more coordinated care to people. I continue to be very skeptical whether net will save a nickel in the process but it's very important for people of all ages and of all insurance status to get substantially better care than they now do in this country when they have complicated illnesses requiring multidisciplinary attention or whatever.

The problem with that is real honest to goodness systems reform takes a very long time and it takes a kind of concentrated, focused, and generous kind of national leadership that we don't have, that we never had, and that a majority of the House of Representatives and that the health care professionals wouldn't stand for even if it existed.

So in the meantime, we're going to have to nurture as carefully and as sort of as aggressively as we can the little buds of innovation that are sprouting up here and there. It's very important that the people who run Medicare and Medicaid not stomp on them in their young delicate kind of wave growth but the fact of the matter is that 30 years ago, we looked at Kaiser and we looked at the Mayo Clinic, which at the time got most of its business on a fee-for-service basis and said this is the way we ought to reorganize the health care system.

The system hasn't reorganized itself spontaneously in those intervening years. In fact, many of its worst uncoordinated, autonomous, disorganized characteristics have

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been substantially accelerated by all the money we've pumped into it over the last 30 years. If we're going to really change the way we deliver care in this country, we haven't even begun to talk seriously about how we're going to do that.

DR. CAROLINE POPLIN: My name is Dr. Caroline Poplin. I'm a primary care physician. I will be eligible for Medicare myself next year.

GAIL WILENSKY: Congratulations.

DR. CAROLINE POPLIN: Thank you. I've submitted something to the Kaiser Health News suggesting that we reduce the difference between what specialists are paid and what cognitive specialists are paid via the RBRVS system but my question is for Miss Wilensky. I think the SGR is coming up again. The organized medicine position is just pay us all more. That's not going to happen. I think you suggested, several years ago, that we have different SGRs for different things, maybe one for procedures and one for cognitive physicians, maybe another one for imaging studies or labs or drugs but it was a long time ago and I don't remember if you actually did it.

GAIL WILENSKY: Well let me explain. I have been railing against the RBRVS then, buying performance standard now, SGR since I was involved in implementing it. I always regarded it as being especially ironic that somebody who is so against price controls at a micro level got to be there when it

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was being implemented and had to spend 90-percent of my waking hours worrying about whether it was going to happen on time.

BRUCE VLADECK: And you did a brilliant job of it.

GAIL WILENSKY: Thank you. I have been, for the last decade, trying to push the Congress hard about the importance of changing how we reimburse physicians and moving away from reimbursing for 7,000 different items and thinking you're going to keep it intact by having a spending limit, which then goes down to the individual fees.

My preferred strategy to fix it is to move Medicare more in the direction that we have moved all other parts of Medicare, which is in terms of bundled payments. It's what we've done for in-patient and now outpatients, what we've done for nursing homes, and especially for home care with the episodes of payment where you worry about the proper price for a bundle of service. You will allow the provider much more discretion about what gets done within that service.

In terms of the general direction, in terms of physicians, ought to be for high costs, high volume interventions of which there are a limited number, and for chronic care. At the very least, we need to have bundles of payment so that you don't have somebody billing for everything they do with regard to diabetes, education, and lab testing, and the visits to the doctor or for a bypass surgery where you

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have many physicians involved and with an expensive hospital intervention.

That’s my preferred strategy because then you would have a very different argument about well how much ought it to cost to take care of somebody with diabetes or somebody who has diabetes and congestive heart failure for a year or for somebody who goes in to have an expensive intervention. If you can’t get yourself to do that, the only kind of SGR that makes sense to me is actually much more micro level than what you described. It would be at the practice level.

Now I mean it may sound radical but there’s no reason you couldn’t do that. it’s not that different from what Germany, some years ago I’m not sure if they’re still doing it, used and the reason this would fundamentally change how you think about the way physicians are reimbursed is what happens to your update reflects the kind of behavior your practice engages in.

Now if you have very small practices, you have some problems about whether you need to do some kind of adjustment for variance. Any kind of practice that you’re now talking four or five physicians, that’s probably not going to be such a big issue. If you had the limit of how much update you get depending on the behavior of the practice then you get, for me as an economist, a relationship between what happens and what you do.

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My fundamental problem with the SGR that no one group or physician can actually affect what happens no matter how egregious you are or how conservative you are and yet you get impacted by what your group does.

Even if you had it at your metropolitan level, I mean think about practicing in Washington, D.C. and your fate, if you're a cardiologist or if you're an internist or primary care physician of another sort, is going to depend on what all of the other cardiologists in Washington do as though you have some kind of influence over them. Then it will just never be regarded as equitable. So it's either bundle the reimbursement or take the SGR or the spending limit down to the level of the actual practice. Then you will at least get people's attention so that what they do influences how they are reimbursed in the future.

BRUCE VLADECK: I agree entirely, absolutely. She's absolutely right.

GAIL WILENSNKY: There are areas where we do agree [laughter] on.

BRUCE VLADECK: That's all there is to it.

TRICIA NEUMAN: Well let me try one then see if you agree on this one.

GAIL WILENSKY: Don't question that.

TRICIA NEUMAN: No, I think there's a prospect here. There's been a lot of discussion about the Independent Payment

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Advisory Board, the IPAB, and whether it is an appropriate vehicle for constraining the growth in Medicare spending.

Of all the things in the health reform law, this one has gotten quite a bit of attention of late. I know one member of Congress has said this'll kill seniors. This has really kind of hit the skids. So I'm wondering is this an area where you might agree? What do you think about the IPAB?

GAIL WILENSKY: I suspect we won't agree. I don't like the IPAB.

BRUCE VLADECK: I don't either.

GAIL WILENSKY: I don't like it. I'm sympathetic with why people have proposed it. Frustration at the Congress not being either to delegate to the administration or authority, my most favorite strategy, or do it themselves in terms about deciding how to restrain spending. To me, what they have done is have a cure that's worst than the disease to allocate this kind of authority, which can have a very important impact on access and how care is delivered to a group of 15 people that once appointed are completely unaccountable to anybody.

As I've said, for me, that is I understand why they've taken the position but it's a cure worst than the disease. So either do it yourself, allocate it to an accountable group, CMS administrator can be fired or dismissed or not confirmed reporting to a secretary that can have the same fate reporting to a president who every four years is accountable to the

American people. I mean I don't like the IPAB. That is just a bad strategy.

TRICIA NEUMAN: Bruce?

BRUCE VLADECK: I agree entirely [laughter].

TRICIA NEUMAN: I should probably leave it there.

BRUCE VLADECK: But just to show that this is not just fatigue on my part [laughter], I've noted in the course of the session as is often the case and as perfectly appropriate, Gail has several times prefaced responses by saying as an economist and since I can now say as a political scientist who's studied constitutional theory and the history of regulatory agencies in graduate school, it's hard to imagine this day and age anyone would think of the Interstate Commerce Commission as a model for how to make better Medicare policy but it's the same sort of political dynamic as well.

I particularly agree with the notion that there is no sort of fundamental legal constitutional reason, at the moment, why the Congress instead of doing what it does every three or four years in reconciliation level down to the fourth decimal point couldn't say and CMS shall take $2 billion out of lab and $4 billion out of the EME and so on and so forth and in fact you probably get much better policy in the process.

The problem with the IPAB is the Congress wanting to have it both ways and that just is not good sort of government. I mean it just is a way of hiding behind an instrumentality

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that they will overrule when the heat is enough anyway and that they will do everything they can once it's created to corrupt the way all the so-called independent regulatory bodies have been corrupted, have been captured by the industries they're supposed to regulate. So just why go to all that trouble and expense to make things more complicated and no better is not clear to me that's consistent.

GAIL WILENSKY: Well this truly is an area where we have strong agreement.

TRICIA NEUMAN: I'm wondering if I should leave it on a high note. I have a few other questions.

DAVID RAVEN: David Raven, Georgetown. I think there is agreement the health care costs are unsustainable. They're twice what other nations experience. They're associated with poorer health status that other health nations experience. Other developed nations have near or complete universal access to health care.

They also have some version of a single payer system. How is it possible to believe that our unique system, other nations also agree that what happens under private health insurance is inequity, poorer health status, and rising health care costs, how is possible to believe that we, in our exceptional way, have the answer unlike the experience of every other developed nation?

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BRUCE VLADECK: Let me just start out with the facts. Many other countries with universal health insurance have very robust and large private sector, private insurance companies. Most Germans are insured by private insurance companies. Most of the Dutch, these days, are insured by private insurance companies. Those are sort of the two model welfare states where Americans should only be so lucky to have the entitlements either the Dutch or the Germans ever have.

So I mean I think that's a misstatement. The real issue though is, to me, the following. I don't think you can control health care costs unless you take the position in one way or another that the rate of health care costs, most conveniently reflected through premiums throughout the whole market, is a matter of public concern. I don't think you need to do a single payer. I don't think you need to set rates identically for private insurers and others.

I think if you have a mechanism like an exchange where people who will do poorly in experience rated markets can be in a community-rated market. That'll drive up overall costs but it's a good halfway measure but I think the real problem is we have, in the name of decentralization and individual freedom and individual entrepreneurism, created a market that is inherently enormously inflationary.

As long as that market continues to be organized the way that it is, we're never going to be able to get control on

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health care costs in this country because with the degree to which income is unevenly distributed in this country and the degree to which income and health status are inversely correlated then health care providers or health care insurers who are motivated primarily by economic incentives, which is some of them, will find a way to make their services available only to those who can afford to pay a premium by charging premium prices and maximize their incomes in the process and then once that's off and running, everyone else is playing catch up.

So I think if we're ever going to get control of health care costs, we're going to have to say in one way or another and the exchanges are a very modest but very productive step in that direction and I think that, in the context of the other changes occurring in the private health insurance market, we are going to begin to see some more efforts on the part of employers and private insurers to do something about health care costs rather than just shifting to the insured population but unless there is a public policy somewhere that says not just the cost of government programs but health care costs in general have to be subject to some kind of limitation or some kind of control, we're never going to control it.

GAIL WILENSKY: I agree with parts, not entirely but I'm not going to go that direction as much to try to respond to the gist of some what you just said. The first is most

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countries have universal coverage. Access is frequently an issue even with universal coverage. It is a good reminder, of course, we know that here that insurance coverage, per say, frequently or at least sometimes, doesn't provide you with access.

It's just that next step. So we shouldn't and having spent a few years working with the World Health Organization and the social determinants of health and looking at the impact of determinants other than medical care on health and on issues of access to that health care, let's not get too carried away with that.

The second is it's fundamentally a political decision. I mean I don't know that I can be more obvious than that. When we had the discussion in this country in 2009, there was a fledgling movement in the House with same 77 Congressmen that are usually trying to push single payer. It basically went no, it was those 77. In 2008, Dennis Kucinich was the only candidate who was embracing a single payer system. He did not do very well.

It is a political issue about how we want to take on these issues. With regard to the insurance exchange, I have a lot of agreement with Bruce that it is a very important potential mechanism to resolve a lot of issues including the fact that we've had, in a secular sense, declining employer-sponsored insurance that's been quite notable since the 1980s.

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We need to have another mechanism for people to be able to get insurance in a structured market organizing entity with some kind of subsidies.

Now I worry a little that the exchanges may be too limited and that they may be too regulatory in the nature but I like insurance exchanges in general because you need to have some kind of an organizing mechanism for people to buy insurance and make sure the insurance is fair that's being bought.

It could end up being that mechanism that really allows us to move away from employer-sponsored insurance but hopefully in an orderly fashion and to be an alternative for people who don't have employer-sponsored insurance, which has always been a big issue either people who work for firms that don't offer insurance or who are in and out of the labor market and for people who are on Medicaid.

I am hoping that maybe some of the newly enfranchised Medicaid individuals, especially those above the poverty line, might be able to buy insurance in the exchange rather than be on their state Medicaid program. So it could be a way for us to do it differently. We are different than most of the European countries.

There are very few that begin to have the diversity that we have in terms of ethnic, religious, racial backgrounds

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and try to think about the health plan that could get through the EU.

That’s a lot closer to what we face. It’s a little exaggerated but it’s a lot closer to what we face as a country than looking at many others. I was in a meeting last year when people were touting all of the wonderful things that were going on in social determinants of Sweden and finally I couldn’t say, alright tell me exactly how many people live in Sweden and I think the number, it was either seven or 9 million, I can’t quite remember.

BRUCE VLADECK: And they’re almost all Swedish too [laughter].

GAIL WILENSKY: Yes and that was my other, yes, is that oh you mean like if we could only get say Minnesota or Oregon to act in a coherent way. It’s like think about what it would take for New York or Florida or California yet alone all those other places to come together. So it really is not quite fair to say they can, why don’t we?

TRICIA NEUMAN: Alright. Well we are about out of time, going to ask you one more question, final question. As I said you’re experts in politics too. Do you see Medicare as an issue in the next election [laughter] or shall this all fade away?

GAIL WILENSKY: No. I mean Medicare and health care, to some extent, are always issues in our elections. I wish

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they would be able to carry over after the election into serious discussions about what we're willing to do different and what that might look like and how do we make that happen. Sometimes there are relatively serious discussions about health care in the elections.

I actually thought 2008 was one of our better years in campaign where we had some rational discussions about health care. It's sustaining that afterward that's difficult. We do better when the majorities are close than if they're too skewed one direction or the other. It may make it easier to pass legislation when they're highly skewed but it doesn't provide civil discourse and ultimately that has huge repercussions following the legislation.

BRUCE VLADECK: As a Democrat, I hope Medicare is a major issue in the 2012 [laughter] elections. It'll maybe distract people from the economy [laughter] and I think Representative Ryan gave us an enormous gift but there's another reason and there really is a very sort of personal problem of mine but it is really striking to me how two incredibly smart, incredibly politically savvy policy wonks were elected as the last two most recent Democratic President and came to Washington without the slightest clue of what the Medicare program is, how it works, what its historical significance is for the Democratic party or the various base

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groups in the Democratic party and what both its political assets and risks are.

It was really distressing to have to watch President Obama learn all over again exactly the same lessons that President Clinton learned in ‘93 and ‘94. Clinton finally caught on.

I’m hopeful that Obama will eventually as well but in fact, this is one of those issues where the bases of the two parties are fundamentally opposed to one another and where even up to the most recent Kaiser polls, one of the few on which the majority of the American public is more sympathetic to the views of the Democratic base than the Republican base. To have leading Democratic politicians not get that continues to really depress me [laughter].

TRICIA NEUMAN: Well on that depressing note [laughter]—

GAIL WILENSKY: We’re not all depressed about that difficulty in learning [laughter].

TRICIA NEUMAN: If you could please join me in thanking Bruce and Gail for coming [applause] and thank you for coming. I think it was a great discussion, a lot of civil discourse and I appreciate you all being here. Thanks so much.

[END RECORDING]

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