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THE 2016 MEDICARE TRUSTEES REPORT:
ONE YEAR CLOSER TO IPAB CUTS?

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PROCEEDINGS

MR. ANTOS: Okay. I think we're about ready to begin. Good morning everyone.

Thanks for coming out on a day like every day in April and May, a very wet day.

I'm Joe Antos of the American Enterprise Institute, and we're here today to talk about the 2016 Medicare Trustees Report.

I want to thank my friends at the Brookings Institution. Many of you may know that AEI holds this type of an event every year. We've been doing it every year for at least the last 15 years. It's longer than that, but AEI records seem to have expired with the turn of the century or something like that.

But we had a scheduling conflict, and, fortunately, I was able to reach out to, as I say, my friends at Brookings, Paul Ginsburg, who can't be here today, and D.J. Nordquist, who paved the way for us holding this event at kind of the usual time at a place not too distant from where the AEI audience often shows up. So, anyway, I'm very grateful.

Many of you may know that AEI is moving. We were supposed to have moved months ago, but let's not discuss that. And I want to thank my friends at Brookings for putting up with the construction debris, the total disruption of pedestrian traffic, and everything else that has gone on just a little ways down the road. Ideally, I'm not making any promises, but ideally we will be better neighbors in the future. We'll see about that.

Anyway, I want to introduce Paul Spitalnic. Paul is the chief actuary for the Centers for Medicare and Medicaid Services. He's not just the chief actuary for Medicare. He's the chief actuary.

And, you know, one thing that I think is maybe not, not as appreciated as much as it should be, but a lot of people often say that they're a little frustrated about policy in Washington, and especially healthcare policy, and certainly Medicare policy. The concern is that, and it's really policy decisions are driven more by politics than they are by analysis.

Well, I don't know if I want to say thanks to the ACA, but due to the ACA, Paul Spitalnic may, in fact, be the most powerful health policy person in Washington. Certainly, with regard to Medicare because there is the IPAB, which we will talk about today, and the actuary's projections determine whether the IPAB will take action or not, at least according to the way the law is written. And there is also the Centers for Medicare and Medicaid Innovation, and once again, the Actuary's Office issues

judgments, required to issue a judgement whether some new approach to payment or delivering services or something related to the Medicare Program saves money or improves quality or does one or the other, and if so, then the ACA has given the secretary the authority to expand that, that project beyond, you know, where it started as a demonstration project.

So, in fact, the Actuary's Office is pivotal to potentially very substantial changes that, at least according to the ACA would happen automatically without the intervention of Congress.

Well, we'll have to see about that. But anyway, at least with regard to those two very important activities, policy analysis will to ~~se~~ some extent hold sway over politics, or at least that's the way it's supposed to be.

And with that, Paul, please do your presentation, and after the presentation, we'll bring the panel up and we will argue with each other, but correcting everybody's mistakes, I'm sure.

MR. SPITALNIC: Okay, thank you. Good morning. Thank you, Joe, for that introduction. As someone that does that does not develop, create, or implement policy, I would dispute your characterization of my authority there.

But I appreciate everybody taking the time this morning. Thank you for the opportunity to listen to my walk through of the 2016 Medicare Trustees Report.

The title of the presentation ~~is~~ that Joe circulated is "Aare we one year closer to IPAB?" And I don't think you're supposed to answer the question of the purpose of the meeting in the first 30 seconds of the discussions, but the answer is, yes. We are one year closer.

We are also one year closer to the Cubs winning the World Series, and me being done paying for college for all of my children. I'm not going to tell you exactly when all those things will occur, but I'll give you a hint. I'm still paying for daycare.

(Laughter).

MR. SPITALNIC: So just to walk through my talk this morning, I'm going to just talk a little bit about the current snapshot of the program, how it's evolved over the years, walk through the formal evaluation of the Medicare Trust Funds.

I will answer the question about ~~one-year-being-closer~~, one year closer to the IPAB and talk a little bit about that. And also we'll talk about an issue that is discussed in the report regarding the 2017 Part B premium.

Before I talk about the projections in the Trustees Report, those projections are 75-year projections. There's also (inaudible), so these are projections that are looking at how the Medicare Program will be changing over a very long period of time.

I'd like to start with this chart just to demonstrate that the program has changed very significantly even under ~~a-very~~, a much shorter period of time. In the past 40 years, the program has moved from that left pie chart where we were talking almost predominantly about an inpatient benefit program to one that looks like the one on the right where there are multiple different categories, multiple different services.

And the point of this is really to not highlight how complicated and diverse the Medicare Program is, it is, but to talk about the limitations of doing these long-range forecasts.

It is impossible to know what this program is going to look like in 75 years, just as it was impossible to know 40 years ago that the program would look like it does today.

However, the reports do have very important useful information to talk about the financial status. In order to understand the financial status, you need to do these long-range forecasts.

We're talking about benefit streams, income streams over many years. In order to understand the (inaudible) so you really do need to evaluate the programs over these long periods of time.

This also highlights how the programs change over time. This is just looking at the proportion of Medicare spending in private plans. This is just going back, what is it, 25 years to see that proportion of Medicare A and B spending that's in private plans has gone from 5 percent to nearly a third of the program. So, again, just highlighting that programs change and we certainly do our best to model it.

So just taking a step back and looking at the current status of the program today, the program is comprised of two major parts, or two trust funds. The Hospital Insurance, HI, which includes Part A, mostly inpatient hospital care, skilled nursing, (inaudible) health, and hospice institutional settings.

And there's also the SMI Trust Fund. This includes both Part B and Part C. There are two separate accounts. Those accounts need to be evaluated separately. Since there is no provisions in law to allow either the benefits to be paid for by the other trust fund, or for income to be coming in differently.

You could see that there is generally roughly 55 million people with HI coverage. Almost 51 million with Part B, and almost ~~42 billion~~, 42 million with coverage in 2015.

The financing of these programs are very different, and so that also leads to the need to evaluate the trust funds differently.

HI, the Hospital Trust Fund, is financed primarily through payroll taxes, 1.4 percent payable both by employees and employers, or 2.9 percent for those that are self-employed.

In addition, there is higher income; there is also a tax on Social Security benefits.

On the Part B side and on the Part D side, those finances are set on an annual basis. In Part B, it's set to be approximately 25 percent of the total cost of providing those benefits. And in addition, those with higher incomes are required to pay an additional amount.

On the Part D side, it's about 25.5 percent of the standard benefit is paid for by beneficiary premiums, and general revenues are the additional, are the primary source for both Parts B and D funding. And also on Part D there is also the income related premium for those high income earners.

So this really looks to summarize what the differences are, the baseline for what we are building the projections off of, and you could see that the differences between the 2016 report and the 2015 report for what we were estimating for spending to be in 2015 are not very different. And, in fact, some of the differences summarized here are actually not even true underlying benefit differences. There's a little more to the story there as well.

But you could see on the income side there was, the actual income was a little bit less than expected, and expenditures were a little bit more than expected on the HI side.

On the Part B side, very close. You know, less than 1 percent differences on both the income and expenditures. And on D, was also a little bit lower, but that really masks what's really happening with the drug benefit.

Talking a little bit about the specific differences on the expenditure side, one of the larger differences was actually a reconciliation payment. Effectively the Part A Trust Fund paid out, had to pay out an additional amount of administrative expenses. There was just a misallocation between A and B, so actually, roughly, \$800 million of the \$3.2 billion difference on the HI expenditures, and the 1.7 deficit on the lower than estimated expenditures was just a misallocation, so the differences in benefit spending was actually even less. Not trying to say we did a great job making these projections, but we did a surprisingly good job making these projections.

And as you could see by these lack of significant differences, most of the projections within the report are fairly comparable to those included in the 2015 report.

This also just looks out throughout the entire 75-year projection period, and summarizes where the income is coming from into the program.

If you look at basically the bottom two, the payroll taxes and the tax on OASDI benefits, and the top line, the deficit, those are basically the HI Part A funding.

And if you look at the middle ones, the premiums, the state transfers, and the general revenue transfers, that's really the Part B and Part D funding.

On the HI side, you could see that the deficit is basically the portion of current revenue sources that will be, that will not adequately finance all of the future benefits that are currently expected to be paid out, or currently committed to from the program.

To talk a little bit about the depletion date, that's usually what, you know, the headline is from the report, and we'll talk a little bit about that in a moment.

But here you can see that that, you know, the bluish section there in the middle, the general revenue transfers that is a large and growing share, and that really just represents a growing contribution of what's happening in the Part B and Part D benefits of the program.

So in order to formally evaluate the status of the trust funds, which is the purpose of these reports, you need to evaluate HI separately ~~from the HI,~~ from SMI. The evaluation on HI is basically are the assets plus projected future income adequate to finance future anticipated benefits. And given that both Part B and Part D funding is set annually for those programs, there are no long-term

solvency issues, but it doesn't mean that there are no underlying concerns. As those benefits continue to grow, they represent a growing share of both GDP and of federal resources, and beneficiary resources.

In addition, in the reports the trustees asks the Office of the Actuary to estimate a illustrative alternative scenario. It's neither an endorsement nor indicative of what is, as I've read it characterized as what we think is really going to happen. That's not the purpose. The purpose is truly just to illustrate what the potential understatement would be to the extent that current provisions of current law are not implemented fully in the future.

So if the two major provisions are related to, one of the future of the ACA. Another is the future of MACRA.

For most nonphysician providers in all future updates their payments rates will be reduced by economy wide productivity. Throughout history, economy wide productivity has been greater than the level of productivity that could be achieved in the health sector.

And so as that differential accumulates, it effectively would serve as, or could serve, if that differential continues indefinitely into the future, that would serve as effectively a reduction of payments to these nonphysician providers, including inpatient hospital, and most others.

On the physician side, the recently passed legislation that repeals the sustainable growth rate formula, the SGR formula, specifies the physician payment rate updates for all future years. And depending on whether a provider will ultimately be in an APM, an Alternative Payment, well, or in the MIPS, the Merit Based Incentive Payment System, they will be either getting a .75 percent, or a .25 percent payment rate update in each and every year into the future. And that's the payment rate update whether inflation is, you know, 1.5 percent, or whether it's 3 or 4 percent.

And given that we are, assuming, the assumption in the Trustees Report is that, basically, the underlying cost index Medicare, the MEI, Medical Expenditure Index, is expected to increase at 2.2 percent for physicians, this payment rate will also create a gap between ~~what's, you know,~~ how their payments will be increasing relative to ~~what~~ how their costs will be increasing.

And so there's an illustrative alternative that presents what costs would be if these two provisions are not necessarily eliminated, but phased out over an extended period of time.

In addition to that, and I know we'll talk about this a little bit later, ~~you also need to eliminate,~~ this alternative eliminates the IPAB provisions as well.

Just looking at short-range, the short-range actually tells a not terribly concerning picture with respect to the HI Trust Fund. You could see that over the recent past, over the last, you know, 20 years or so, income and expenditures have generally been moving in the same direction. You could see income dropped off after the recent great recession, and is actually expected to grow at a faster rate than expenditures for the next several years. Starting in 2020 and thereafter, expenditures are expected to exceed income.

So in the short range, things don't look so bad on this chart. This chart otherwise shows what the account balance is within the trust fund. And, basically, the trust fund in this year's report is expected to be depleted in 2028. That is two years sooner than estimated last year. And on here you could also see the prior year trajectory. And generally speaking, when you have relatively low balances, it doesn't take significant moves to make, to have a change in the timing of when the trust fund will be depleted.

And as we'll walk through, the relative changes in the projections are fairly minor, but we do have this two year earlier depletion date.

So looking at the bigger picture is really the way to characterize the actuarial balance of the trust fund, and it really looks at a present value of the future income, and the present value of the future costs, and relates it to taxable payroll. That's the taxable payroll is the basis for the current payroll taxes into the system so that's a good measure for how, you know, the cost and income are moving forward in these projections.

You could see that there are some differences here between the 2016 and 2015 reports on both the income and the cost side. The net bottom line difference is that this year the actuarial balance is, the deficit is slightly larger than it was estimated to be last year by .05 percent of taxable payroll. It's a relatively modest change in any terms, but we also had a methodological change this year.

In prior reports, there is a small group of what's called uninsured beneficiaries, and I did not give the title of uninsured beneficiaries to these people that are covered in the Medicare Program.

But, basically, there is a group of people that do not have 40 quarters of coverage that get bought into, that can buy into the HI Program.

There's a premium rate set for them each year. It's roughly about 600,000 people, and the assumption, in prior reports we've always had a difficult time just getting data on both the cost and on the revenue side for these guys, but we have been able to break this out this year, and we have built it into the projections.

And so there's a methodological difference in that we've added both the income and the cost rate for these uninsured beneficiaries. And as you could see, our prior assumption was that it was, these people were not affecting the actuarial balance all that much, because the expectation was that they're fully paying the full cost of the premiums, and they've got benefits going out.

We were never able to align that these are truly average beneficiaries, and that their cost truly match up with the average.

Turns out that they're very slightly ~~most~~more costly. But as you could see, these numbers are fairly small so these do not move things all that dramatically.

And so you could see that even accounting for these differences, the income rate is hardly changed, and the cost rate is slightly changed. And the biggest reason on the cost rate is that there was a slight bump in certainly, in the short-range inpatient utilization assumptions. And, basically, the assumptions are that for '16 '17 the rate of decline of inpatient admissions was lower than what we expected it to be.

So inpatient admissions are still slowing, but not as fast as what was projected last year.

This section gets into the finer details. And you're not wrong if you say that minus .01 is a relatively small differences, and that is the largest difference for any one element of these factors contributing to the change in the actuarial balance.

The change from minus 68 percent of taxable payroll in the 2015 report to the minus .73 percent of taxable payroll in the 2016 report evaluation period, so we're, 75 years has just shifted one year further down. We, basically, replaced the relatively lower deficit year with a higher deficit year by, basically, shifting the period forward.

The base estimate interest includes the incorporation of additional data. Hospital (inaudible) as I mentioned on the inpatient side, some other, there's a whole host of details in terms of a whole host of assumption changes from year to year in these reports. I'm not sure anyone other than Keith Fontenot—~~I~~ was up 'til two o'clock last night reading all of them and getting excited about them, and talking about them with Dave this morning, but there is a whole host of changes to the underlying economic and demographic assumptions and ~~methodological~~methodology that was that insured difference.

So all told, there is not much difference in this year's report from last year's report with respect to the actuarial status of the HI Program.

This is another way to look at the program in terms of looking at the income rates and cost rates. You could see that these lines are on the cost side. The cost sides increase at one point, and you see in 2028 the cost and the income rates come down. And, really, what we're showing there is that once the trust fund is depleted, only benefits that are currently being, only, the only use of revenues will be those that are coming into the program will be able to be used to provide for benefits at that time.

You can see that on the left side of the chart, in 2028 when the fund is depleted, income will represent 87 percent of what the expected costs will be in that year. So even when the fund is depleted, it's not that there is no more income and no more benefits, and the program shuts down. It's just that the amount of income will be inadequate to fully fund all of the expected benefits.

And this really looks at the differences in the two reports, and as I mentioned earlier, there's not a lot of difference in those two lines.

However, if you layer on top of those two lines what the cost would be under the illustrative alternative assumption, you could see that there is a pretty significant divergence between the cost estimates projected under the current law approach that's included in the Trustees Report, and the reference to illustrative alternative assumption.

And so those productivity offsets, in particular on HI side, really lead to a very significant difference in terms of what the costs would be under this program. You can see that those differences start off very small, but it's amazing about compounding that when you start off with small differences

over a very long period of time, they mature into very large differences, and that's really the point of the illustrative alternative is just to demonstrate that should those cost savings aspect of the programs prove to be not implemented, that costs under this, as illustrated by this alternative projection could be significantly higher than represented in this report.

On the Part B side, this is -- also the fact that the financing is set annually, there is never a lot of interest in terms of looking at the income and outgoes on a comparable basis because the program is always in financial balance.

As you can see though, as the program continues to ~~more~~ mature and we have more baby boomers coming through the program, we are expecting that costs will continue to increase.

Similar story on the Part D. And you could see that we are slightly higher than where we were estimating last year on the Part D side.

Again, this is -- those differences are not very large, but they, those differences are generally attributable to an even stronger increase in ~~speciality~~ specialty drug use in the Part D Program than we were estimating last year.

This kind of just pulls the two programs together. See ~~sing~~ how the premium contribution and the, basically, the federal expenditure contribution of this program change over the next 75 years, and we get from (inaudible) as a share of GDP, so, you know, the programs eventually get up to just under 4 percent of GDP.

Again, looking at the bigger picture of the changes from the 2015 to 2016 report, Part B expenditures as a share of GDP was basically right in line with what we were expecting for 2015. And for the longer range of 2085, again, not much of a difference there as well.

Similar story on Part D. moving in little different directions, but, again, not a lot of difference in those underlying projections.

This looks at the long-range as a share of GDP just for Part B, and you could see some of these, the payment rate update in particular, actually is what's causing those declines in those, in the later years. The fact that this peaks out at 2.5 percent and then drifts downward thereafter is largely due to the fact that the payment rate updates are just not expected to keep up with, in this case, the underlying GDP growth.

So, again, it's important to compare this to, this, actually, compares total Medicare expenditures as a share of GDP. We're currently at 3.6 percent of GDP. Under the current law projections expected to grow to 6 percent of GDP, but under the illustrative alternative, it's expected to grow up to the 9.1 percent. So, obviously, a significant difference there.

So now we get to Joe's favorite part of the talk, the IPAB. And so each year the chief actuary needs to make a determination as to whether or not the Medicare calculated amounts exceed a certain target amount. And for the 2016 determination, the Medicare growth rates are 2.21 percent as compared to the target rates of 2.33 percent. Therefore, there is no determination in the 2016 Trustees, based on the 2016 Trustees Report. And I issued that determination yesterday after the report was finalized.

To talk a little bit about how this calculation works, basically, the Medicare is, the Medicare portion of the IPAB determination looks at a five-year average of Medicare per capita costs. Looks at the current year, two years prior, two years forward, and that's the basis for that calculation.

The target rate is set as a function of either CPI and medical CPI for the first, was it through 2008-2017, and then transfers over to a GDP plus 1 type calculation.

But if you look down one row at the 2017 row, you could see that the Medicare calculated amount of 2.82 exceeds the target of 2.62. So based on the current Medicare Trustees Report projections, it will be expected that the IPAB would be that there would be a determination for the IPAB in 2017.

What does that mean? That means that I would have to issue that the ~~Medicare targets exceed the~~, the Medicare expected growth rate exceed the targets, and that savings will need to be generated to effectively account for this .2 percent difference.

So that would, so if these projections exactly hold next year, and at this point next year, that's the determination, and I'll say that there is effectively however many billions of dollars would need to be saved through various proposals. So that will be done in 2017.

The next step would be in 2018. A proposal would actually need to be delivered to Congress. Should be delivered by the IPAB. If there is no IPAB in place, then it will be delivered by the Secretary.

Congress then has the year to consider it. If they pass something that equally generates that level of savings, then that's done. Otherwise, that savings proposal would be implemented in 2019.

So the sequence works. For example, for next year, 2017 would be a determination year, 2018 would be a proposal year, 2019 would be the implementation year.

I do not have the answer as to when the Cubs will bring the World Series.

The other key issue that's really highlighted in this year's report is around the Part B premium. And I'm going to walk through where we were last year when we were having this conversation, and that was that there was, in last year's report, there was an expectation that there would not be a cost-of-living adjustment for Social Security benefits in 2016.

There is also a hold-harmless provision in Social Security that does not allow net Social Security checks to go down. And that includes the effect of Medicare Part B premiums that are withheld from Social Security checks.

So roughly, 70 percent of beneficiaries despite the fact that the Medicare Part B premium went up from 104.90 in 2015 to 121.80 in 2016, roughly 70 percent of beneficiaries that have their Social Security, that have their Part B premiums withheld from Social Security, they're continuing to pay 104.90 in their Part B premium this year.

Now, if not for provisions of the Bipartisan Budget Act of 2015, the remaining 30 percent would have had to shoulder the entire increase of all of the necessary premium increase to generate the adequate funding for the program. But the Bipartisan Budget Act was passed, and basically said we'll allow for a transfer from general revenue into the Part B Trust Fund. The amount of that transfer will effectively be the amount of the foregone revenue for the fact that the hold-harmless provisions are preventing beneficiaries to contributing to the program to the full extent of what they otherwise would have been calculated. That will count as a transfer into the Part B program. We're also going to add \$3 per month to the otherwise calculated Part B premium until that transfer amount is fully paid back.

There is also a provision that says that if there is no cost-of-living for 2017, these provisions will again apply. So if there's a zero percent COLA for 2017, then there'll be another transfer, there'll be another \$3, and we'll, basically, be able to kind of continue on.

So the expectation -- as mentioned, BBA provisions will also apply if there's no COLA in 2017. On the other side, if there's a sufficiently large COLA, cost-of-living adjustment for Social Security benefits in 2017, the hold-harmless provisions will not have a bite to the premium calculation. If the 70 percent are experiencing, you know, the \$10 or \$15 increase in their Part B premiums, then there would not be this foregone revenue that you would need to otherwise collect from the smaller 30 percent of beneficiaries not held harmless.

Similar implication -- the Part B deductible I failed to mention is also calculated based on the same function of the premium. So to the extent that there's a large increase in the premium, there's also a large increase in the deductible.

So the Trustees' assumptions are that there will be a .2 percent cost-of-living adjustment for Social Security. At .2 percent, beneficiary Social Security checks will go up by a small amount, .2 is not very large. On average, we're thinking it's about \$3 a month. Those beneficiaries would then contribute that additional \$3 per month to the Medicare Part B premium, but that's not sufficient to make up that roughly \$15 gap between the current premium, and what they're currently paying, the \$104.90.

So we still have that leveraging effect of where we need to get the additional funding from, the relatively small number of the 30 percent that it would otherwise be paying.

As a result, we expect, the projection is that those 30 percent would be paying \$149 with the 2017 Part B premium. It's similar to the concern that we had last year when the expectation was that the hold-harmless provisions would also apply.

It's a little bit different this year. There is less certainty as to whether this is going to occur, so there's still a chance that it will be below zero. There's still a chance it will be above one. So there's less certainty on the COLA.

The difference that we have to make up aren't as large as what we had to make up last year, and there's just going to be more information available as time goes on.

So that the CPI came out last, a few days ago, and looking at that, we're at plus .09. So that pretty much is the worst possible situation. Plus .1, .1 of one 1 percent COLA would be the worst possible situation for the amount that would need to be made up for in beneficiary premiums.

So, obviously, this will play itself out. Last year facing a similar circumstance, not exactly the same circumstance, there was a legislation that addressed it. We'll have to see how this is going to play out as more information becomes available.

I think that is my presentation. So at this point, I'm going to turn it over to Joe to I think ask me some questions --

(Applause)

MR. SPITALNIC: Thank you.

MR. ANTOS: Thank you.

(Recess)

MR. ANTOS: All right. Very good. Well, thank you very much, Paul. That was, that was pretty heavy going on an early morning, I just say. But for the frequent attendees at this even over the years, you're a hardcore group of people, and so you're able to absorb the arithmetic blows pretty well today.

Before I introduce everybody, I'd make a few comments, and I actually wanted to raise a question with Paul about the ~~IP~~IPAB determination. And that really has to do with the point that the IPAB determination is based on projections. And so is it, is my assumption correct that each year you look two years back, you look two years forward, but it's a new set of projections every year based on changes that may have occurred in the economy. Changes clearly could have occurred in the Medicare spending or Medicare revenues over the course of that year.

So, in other words, looking at the numbers this year doesn't necessarily tell you, or give you a clue about what's going to happen next year with regard to the IPAB determination; is that right?

MR. SPITALNIC: Well, I'd hope it would give you a clue. Basically, it is what our expectation is going to be for the future, and, obviously, the future is uncertain. We do issue these reports each and every year. The numbers do not stay exactly the same each year. The differences between the 2016 and 2015 reports were relatively modest. That doesn't happen every year. There ~~is~~ are often changes.

When you're talking about near term projections, so projections one or two years out there's generally more confidence in those. And as you mentioned correctly, ~~that~~ this looks two years back and two years forward, as well as the current year.

And so to the extents that we're looking at, that will be included in the 2017 determination at least is partially based on '15 which we have a pretty good idea about, '16 which we have some idea about, and then decreasing as you referred, yes, there is uncertainty. ~~There-That~~ is, the projections will be different next year. However, when you're talking about making a projection two years out versus 75 years out, obviously, there's a lot more confidence.

MR. ANTOS: Right.

MR. SPITALNIC: But the fact that we're talking about a relatively small difference expected next year so we're only talking about .2 as the difference that would need, the level that the Medicare is expected to exceed the target, it takes relatively small movements. If there was a .1 movement on the Medicare side of the calculation and the .1 side on the target, there would not be a determination next year.

So, yes, this will be done again next year with updated information. The projections will change, but I think there is a fair likelihood that this, that the IPAB determination will be made next year.

MR. ANTOS: So much for the Cubs. I wanted to make a few quick comments about what I have always thought is a somewhat unfortunate focus of the press on certain aspects of the Trustees Report kind of missing, I think, missing some of the major points that are really being expressed here.

So here's a headline now. The author of the story didn't write the headline, so the author of the story shouldn't be blamed for this, but the headline writer's conclusion was Medicare Trust Fund running out of money fast.

This was in The Hill. The story actually doesn't really say that. It's reflecting the fact that the so-called insolvency date for Part A moved up a couple of years.

You know, this is the kind of headline you could have written almost every year for the last 50 years. What's fast? What is running out of money? What does all that mean? And the answer, the answer is that it's not at all clear. And I think the point that Paul made that I wanted to emphasize is

that the Trustees Report is making projections based on current law. That means that they assume, and this is the only reasonable assumption, I think, they assume that whatever is on the books now, will actually happen.

In order to make some other assumptions, you, basically, are imagining a different set of laws and different set of circumstances. So you have to work with your have.

It's comparable to CBO's problem with baselines. They have a ten-year baseline. In essence, Paul is generating a 75-year baseline. But it's the same exact kind of a problem. You can't imagine an alternative universe, but you do have certain things you connect yourself to, and that's current law even if you think that current law, especially in the 75-year context, might not hold.

And, of course, we've seen that with the Medicare Program, the sustainable growth rate. The SGR was supposed to be a perpetual program, and after the first couple of years every single year, oftentimes several times during the year, Congress would make some sort of an adjustment to soften the blow.

There is a separate report available on the actuary's [websitesite](#) at CMS which for those of you who really like numbers is a great report, but it does make important points, and it's not the numbers. It's the explanation that really matters here.

So, you know, it leads off with the statement that the intent of this report, (inaudible) attempt, the Actuary's Office's attempt, is to help inform Congress and the public at large that it in an evaluation of the financial status of Medicare that is based on the provisions of current law is likely to portray and overly optimistic outcome. That's an important point.

It ends with the statement that this analysis highlights the critical importance of finding ways to bring Medicare costs and healthcare costs in the U.S. generally more in line with society's ability to afford them.

That's an important message. It's a message that could have been, should have been, probably was made almost every year for the past 50 years.

So, yeah, the Medicare Trust Fund is running out of money fast, but that isn't necessarily motivating the kinds of policy changes and the kinds of changes in the real world, the kinds of changes in the delivery of healthcare, the kinds of changes in the way the health sector is organized, and the kinds of

changes that are necessary among all of us, the public, in terms of what our expectations are, what our responsibilities are for our own health. These things don't seem to be moving very quickly.

The other point that I guess I would make has to do with the hold harmless. Yesterday, Andy Slavic was quoted as emphasizing that we've, you know, a fact that we all know, that Medicare spending growth has slowed down and is still quite a slow rate of growth compared to historical averages.

Why would he emphasize that since everybody who pays attention has known this for years? The answer is that if you're looking at the kinds of increases in the premiums that could occur for roughly a third of the Medicare beneficiaries. Something like 13, 12 or 13 million people.

You want to give them some good news, but, frankly, that's the kind of good news that won't help if you're going to see your premiums go up by \$40 or \$50, and in particular, let's see, somewhere I have my, I have the comparison with last year. I'm not gonna find it, am I? Yeah, here it is.

So here are some numbers that I don't think Paul gave you, but it's sort of instructive. So in last year's report, what you could tell by looking at the premium table is that the 2016 premium would have been roughly \$105 a month for people who were held harmless. But the expectation was that for those who were new the program, or weren't held harmless, and were paying the standard premium, they were gonna pay about \$160. For those who had to pay the income related premium in Part B, the premium potentially could have jumped from \$335 a month for those paying the highest amount to \$510 a month. Those are gigantic increases, and we're talking about a few people. We're talking about 13 million people. We're also talking about every state that has to finance dual eligibles. Dual eligibles or the states are not held harmless.

So that suggests that that's going to be a real issue, say, in October, or sometime before the election. I can't believe that there won't be some real push on the part of the administration to deal with that issue before the election. And the problem I think we're going to have is that Congress may not be real eager to make any changes. They are not going to be in town much after this week, and September is supposed to be a full month, but the odds of that actually happening are pretty limited.

So I think that raises some interesting things to be looking for in observing policymaking over the next few months.

Anyway, let me introduce the panel.

MR. SPITALNIC: Joe, do you mind if I just --

MR. ANTOS: Oh, yeah, please. Yeah, please do.

MR. SPITALNIC: So I think you did highlight on I think the most important aspect of both the Trustees Report and the supplementary illustrative alternative memo. And that really is, the purpose of both of these documents are to inform. Inform the Congress, inform the public of the status of these programs, what's happening with these programs.

And so that, I'm glad you picked up on that because that truly is the purpose of what we're doing here, and that's the reason why I'm here today is to kind of get this message out of what's happening in these, these critically important programs. So thank you for that.

Second, on the need to align or to kind of get future cost growth in line, there's, obviously, a lot of work that's happening at CMS that's attempting to address that. There is a whole host of work that's going on in the Innovation Center. The basic transformation from a pay for quantity of services to pay for quality of services and the like.

So there are, I think there's a lot more attention to that than there has been paid for a number of years. And we'll see if these bear fruit. Some have demonstrated some amount of promise to date. Others are still waiting to bear fruit, but I think there's a lot more work going on in that space than we have seen in past years.

MR. ANTOS: Yeah.

MR. SPITALNIC: On hold harmless, I think I did mention that that would have a large increase, and it truly does. There are people today; the premium today is \$121.80. You know, last year when we were talking at this time, as you mentioned, the expectation if no action was taken the premium would jump up to \$159. Now, we're projecting under potential circumstances with less certainty, but there is a significant risk that we'll be facing a premium not unlike \$147 that we're currently projecting.

MR. ANTOS: Yeah.

MR. SPITALNIC: So these are important issues, and whether or not there is the appetite for legislative action to address this like there was last year, I'll certainly leave that to the rest of the speakers who I'm sure have an opinion on.

MR. ANTOS: There's lots to be said for fear. Anyway, let me introduce the rest of the panel. First, Keith Fontenot, who is a visiting scholar at the Center for Health Policy at Brookings, and he's also a managing director at the firm Hooper, Lundy & Brookman.

Fuller bios were available, so I'm just going to introduce people in terms of their current positions.

Bob Moffit is a senior fellow at the Heritage Foundation Center for Health Policy Studies, and I can't not say that Bob Moffit, archconservative, is a regulator in the State of Maryland.

(Laughter)

MR. ANTOS: So much for archconservatism.

Alice Rivlin is a senior fellow at the Center for Health Policy at the Brookings Institution.

And finally, Jim Capretta is visiting fellow at the American Enterprise Institute, and he's a senior fellow at the Ethics and Public Policy Center.

So, Keith, take it away, please.

MR. FONTENOT: Thank you, trustees. Thank you for coming out on such a dreary day.

First, I'd like to start and just thank Paul and his team. I had the pleasure of working with them for over 30 years, and his predecessor, of course, Paul wasn't there 30 years ago, but Rick Foster taught me what, all I know about Medicare and Social Security. And so if there's any gaps in my knowledge, don't blame Paul, blame Rick.

But their job really, and I take a little issue with Joe on this, is they don't exercise power. That's not what they do. They do their best estimate. They do their best analysis. They do the best numbers.

They're just like CBO in that regard. They reason those issues are vested in them is because they can be trusted to do that. But they also have an operational rule that I think many people forget about in this system is just like actuaries in the private sector, they review all the bids, all the underlying stuff in the Part C and Part D Programs. So they have, you know, they have quite a load on their shoulders. They do an awful lot of work.

The second point I would make is that, you know, I know Paul would agree with this, all projections are fraught with uncertainty. Healthcare more than any others. And the further out you go, the worse that uncertainty is.

And you'll see in there, for example, they do high and low scenario estimates in addition to the illustrative alternative scenario. And you can see the range of results there is startling. And all those outcomes are plausible in some degree.

So I think the most useful way to look at this is to see what it really tells us about the dynamics of the program, about what's going on, about the policy issues that it identifies, and so forth.

So the overall message I would take away, little different from Joe's, is that in the near term the ACA is working. In the long term, the trustees point to the challenges of adequately financing the program, of giving providers tools to sustain productivity, to live with the planned reimbursement levels, to managing the cost of prescription drugs, and other issues like the premiums.

Start back, this is the lowest five-year period in history of per beneficiary growth in Medicare. I think we should stop for a second and say, hey, that's not a bad thing.

Jim and I worked together at OMB many years ago and it was going the other way, and every time you got a report, it was like worse, and worse, and worse news.

I think we should actually step back and say this is not bad news. It is -- I agree with Joe completely that 2030 to 2028 thing is not, it gets overplayed in a lot of ways which I'll talk about. But if you look at the difference between 2009 and today, it's absolutely staggering, and we predicted it in, or Paul or his predecessor predicted in 2009 that Medicare would grow to over 11 percent of GDP in the prediction period. Right?

Today, that's 6 percent. And even if you take the illustrative alternative scenario, that goes to 9. So let's say we're in the 6 to 9 range somewhere. That's a heck of a lot better off than we were. Five percentage points in GDP is a whopping big number.

And GDP today I don't know exactly, but probably in the 17, 18 billion range showing the present value. That's a lot of money.

Now, he points correctly to the issue of can we sustain that over the long term, and I think one way to look at a lot of what's CMS is doing today is to try and give providers tools to be more productive over the long term.

By and large, this year I would say is a series of small tweaks that accumulate in a slight negative. Right? And I think that's entirely appropriate. I think that's entirely appropriate.

And so when I say don't fixate on the date change of 2030 to 2028, keep in mind that even at that point that the Trust Fund is predicted to become insolvent, that's only the HI Fund, number one. Number two, there's still 87 percent, roughly, of the revenue coming in you need to pay the full benefits.

And we have time. We're looking at this in 2009. The projected date was 2017, so it would have been next year. So the world is better. I think it's important to stop and acknowledge that.

But I think the Trustees also do a great service in calling in particular to the need to give attention to the long-term stability and financing of the program. And in this they do a very nice of balancing both what Paul described as the fund perspective, fund perspective, not the fun perspective, the fund perspective where you look at the financing of each individual element of the program.

By the way, they built this up system by system, program by program, element of spending by element of spending to get to an overall picture.

In the long-term, you have to look at the stability of the program relative to both the national economy and the federal budget. Okay. And there is an Appendix F, famous Appendix F. Those of you who don't read the appendices, I comment this one to you because it really does get at this question. And this, by the way, is a very controversial topic in the actuarial world, I understand.

But it does call out some really fundamental issues. The first is that we're in an aging society. At one point, there were four workers for every retiree. As you go out in the projection period, it's two workers for every retiree. Retiree plus disabled, I should say.

The baby boom is not something that goes away and is replaced by a world like the old days. Baby boom is really an aging society, and that's a fundamental thing we have to reckon with.

Other work done here at Brookings by Doug Elmendorf and Louie Shaner really points out sort of these intratemporal issues, number one, and number two, how to think about this relative to the federal debt.

As a budget person, and as someone who formerly worked for Alice Rivlin, and Jim Capretta, by the way, I cannot not point out the relationship between these programs and the federal budget. It is integral. Not ~~estopic~~ butentopic but we can touch on that more later.

The second issue they really point to is the level of payment, the ACA productivity adjustment over the long term. And Paul has published this. Joe noted a separate memo that talks about that.

I want to quote for you something from the book. It says, "The Trustees believe that this outcome is achievable if," and then they go on to say, "if providers can achieve the level of productivity that's there."

We don't know what that will hold in 30 years or 40 years. But we do know that in the short term, it seems to be working at least in part, as Paul pointed out to me before the meeting, because productivity growth in the national economy has been a little lower than expected.

So how these things play out, we don't know, but you have a focus now on issues at CMS in a very, very concerted way that wasn't there before, and I think that's fundamentally a good thing too.

There's another element in here that Paul pointed to that I think is equally important to this question of the long-term productivity growth, and that's MACRA, Medicare and Chip Reauthorization Act, which replaced the old sustainable growth rate system for setting physician payment rates.

It's a complicated system, and I won't go through all of the details of it, but the simple point that's made in this report is that over a longer term here, and I think that means 30 to 40 years, probably 20/30, 20/40 range, and actually the payment rates that result under MACRA may be less than they would have been under SGR.

Now, there's a lot of mathematics involved there. It's a very complicated set of issues, but there are some key add-ons or bonus payments in the MACRA system that expire in 2025, and that creates a little bit of a cliff.

So there's many issues that they point to that you have to, you might read it. You might read it just to say it's simple statement of fact. No. That's a big policy issue. It's a very big policy issue.

The premiums, I think, are another issue. And I'm going to tell you the premium issue is not a new one either. It was not just BPA, and I know Alice will remember this going back to the eighties when the hold harmless led to an erosion of the premium in a way that it dropped well below 25 percent of program costs, and then we put in a different set of rules.

And so we are still struggling with this. But I think it's an appropriate struggle in a lot of way. There's 55 million people on the other end of this system. That's a lot of people. And they're all subject to, or many of them are on fixed incomes, most of them on Social Security or something else.

And so it's important to pay attention to what the impact of the premiums is. And the hold harmless does result in some anomalies, let's say, where people that come onto the roles pay the new premium, the full freight. People who are not paying through their Social Security benefit may pay the premium at the full rate. States who are paying on behalf of beneficiaries pay at full rate. And I believe, also, the upper income pay at the full rate.

So, you know, Congress did what it thought appropriate the last time and stepped in here. I just point out to you that this is an ongoing issue, and in a world of such low inflation as we have now, a lot of the things we think about are going to need attention.

So I'm going to conclude here quickly. Just one quick note:--There's two vacancies on the Board for public members, and I hope that we see those filled. I think what the Trustees have done here is very reasonable and very within the bounds of everything in terms of actual real norms. But I think over the long term, it's good to have public members, and I hope we get some there.

So in conclusion, I think it's another great job. It's complicated stuff. It's a complicated program, but it's critically important to an enormous number of Americans, to all the providers, the physicians, everybody on the other end of this system.

And so once again, thank you for all (inaudible).

MR. ANTOS: Thanks, Keith. You are a little overly optimistic for my taste, but that didn't surprise me.

MR. FONTENOT: Jim and I on average equal out.

(Laughter).

MR. ANTOS: Well, I'm going to try to bring the balance more my way now. The two main points that Keith made, as I understood them, were that Medicare needs to save itself some real political problems. It needs a slow growing economy. A good recession would really help Medicare.

(Laughter).

MR. ANTOS: That would avoid, that would put off any kind of a hit from IPAB. And then, of course, we also need rapid inflation because that solves the hold harmless problem.

You got it. Bob.

MR. MOFFIT: Well, I can't --

MR. ANTOS: No, wait a minute.

MR. FONTENOT: You have a right to respond --

MR. ANTOS: Okay.

MR. FONTENOT: I'm not saying you need either of the alternatives. But the fact is that those changes hasve made a difference in the Medicare Program in a different way.

MR. ANTOS: Okay.

MR. MOFFIT: Now, it's my turn. First of all, ladies and gentlemen, very seriously, this is an excellent public service by the Trustees every year. I mean, excellent. It ranks with some of the best work.

It's done by CBO. It's not just simply their presentation of A, B and D. The appendices are fantastic. They're full of data that is very useful to researchers. They give you a historical perspective, and they give you some kind of an idea about where this enormous program is going.

The thing that struck me reading the report. I didn't read all 262 pages, but that's the truth. But I did read most of it, actually. And the thing that struck me about this report in 2016 compared to 2015, the thing that was surprising was to a large extent the absence of surprises.

This report in many cases simply repeat many of the things that the Trustees have said in the past, and in many, many areas, many paragraph they actually use the exact same language, I mean, literally, word for word, paragraph by paragraph.

What's not surprising is that the HI Trust Fund has deteriorated to some extent so we have a two-year, we're closer to insolvency in two years or 2028 as opposed to 2039. There's nothing surprising about that.

In January of this year, the congressional budget office projected that, in fact, the Trust Fund, HI Trust Fund would be insolvent in 2026. Keep in mind, a lot of this is still very uncertain, and the Trustees themselves say that if we under the high cost alternative things which do not appear, obviously, do not appear likely, the Trust Fund could actually be insolvent in 2022.

The thing that they repeat year after year, and Congress doesn't seem to be able to absorb this, is that the Trust Fund does not meet their test of financial adequacy. They've been saying that for a very, very long time. In fact, they point out on page 7 that the Trust Fund doesn't meet the test of short-range financial adequacy, and hasn't done so since 2003. Members of the House and Senate please take note.

They also point out that the long-term actuarial balance is inappropriate as well, no well.

I do agree though, I think has made an excellent point, and so has Keith on this media obsession with the HI Trust Fund. And you've all seen the headlines. Medicare going broke. Medicare faces with bankruptcy, or going broke, or becoming insolvent. And it makes great headlines.

Congress, it has never gone insolvent, the Trust Fund, and it's inconceivable that Congress would allow it to become insolvent. They raised taxes, payroll taxes I think about ten times just to make sure in the HI Program that it would be financially solvent, and so I think, you know, that obsession with the HI Trust Fund is something that analysts, I think, we're all agreed on that. I think we have to have a long conversation with the media perhaps over coffee, but just a long conversation with the media to explain that, in fact, the outlook for the Hospital Insurance Trust Fund says little, very little about the long-term financial challenge posed by Medicare, and I think on that we're also in agreement.

The Trustees point out that Medicare spending is going to grow faster than workers' wages in the general economy. It will consume greater share of the federal budget. It's going to crowd out other budget priorities, and, of course, consume larger and larger shares of the GDP.

They also point out that the Medicare Program is going to grow faster than other segments of the healthcare sector. For example, in 2027, Medicare outlays are going to grow by 6

percent, the economy by 5.5 percent, national health expenditures, all spending in the country by 5.4 percent, and private health insurance by 5.1 percent. That continues for the foreseeable future.

The Medicare Part B problem, I think, frankly, that if we actually end up, it's uncertain right now, but if we end up with 30 percent of retirees faced with \$149 a month, you can be rest assured, you know, despite the fact that Congress is running out of time, that they will find time to preserve themselves. And what they do is they will fix it, and, hopefully they will fix it just like they did last year.

I was absolutely pleasantly surprised that they decided to adopt the social insurance policy that people who get the benefits should pay for the benefits even if it's a minor supplemental premium increase. Excellent idea. I hope they do it again if this should come to pass.

The one thing I do want to mention is that with regard to the long-term outlook, I'm normally criticized on bringing this up because it's not something that's polite, but, you know, that is the unfunded obligations of Medicare, you know, the 75-year projections. You know, the benefits that are promised but not paid for, how are we going to pay for them.

Last year under current law, that means that MACRA, and ACA, and all those things will actually go into effect, they had a projection of \$28 trillion over the 75-year period. We gotta come up with \$28 trillion. This year it's a little worse, \$32.4 trillion, and God knows what it would be with regard to the alternative scenario.

But the point is this dwarfs the national debt of \$19 trillion, and I think the public has got to be better educated on exactly what is facing them along the next several years with regard to the requirements to keep the program safe.

Doctors are going to be absolutely livid when they absorb the fact that they spent so much political capital enacting MACRA only to find out to get rid of the SCR, which was an obsession, I mean obsession. There were members of Congress who were saying they'll do anything to get rid of the SCR. Now, I don't know if the actually meant that, but people actually said that.

But as the Trustees point out, getting rid of the SCR they did it, but under the current payment system, doctors are actually going to get paid less, the gap will grow over time. When they absorb that fact, I think we'll see more trouble on Capitol Hill about physician payment.

The ACA. Keith says it's working. -Well, okay, but here's the deal. What the Trustees tell us is that if we maintain the payment system in Medicare Part A, and I quote from -page 194, quote, by 2040 simulation suggests that approximately half of hospitals, 70 percent of skilled nursing facilities, and 90 percent of home health agencies, would have a total negative facility margin raise the possibility of access and quality of care issues for Medicare beneficiaries. Laminate that. Put it over your fireplace.

One more thing I will say about the Trust Fund reporting, there's a lot of other things to say, but I'll just mention one other item. I think this is a terrific report. I read them faithfully every year. They are full of terrific data. And I think the Trustees have done a great job in presenting this issue, and they presented it fairly.

I don't want this to be misunderstood on my part. I think it is a bad thing, a bad thing, as a matter of public policy that public trustees, the independent trustees have not signed this report. I'm not blaming anybody. I know that the two current public trustees are before the Senate Finance Committee and delayed a bit, but when the National Commission on Social Security Reform their report in 1983, they remarked that adding two individuals from outside of the executive branch would instill confidence in the integrity, that was their language, instill confidence in the integrity of the process.

We've got to figure out a way to prevent this sort of thing from happening again. We need independent, we need independent ~~personalities~~ personalities signing this. This cannot be simply an administration project. It cannot.

The other thing I would mention again, is that once again the Trust Fund is late this year. Once again, this is a routine problem. The statutory deadline for submitting the Trustees Report to Congress and the public is April 1st. That's a statutory deadline. It's the law as they say. It's not a good idea or suggestion or maybe when you get around to it.

The problem is, once again, this is not something that is, I'm not blaming the Obama administration or anything like that. This has been going on for a long time. My suggestion is that if Congress wants to get things right here, what they should do is to make sure that public trustees are in place until they are physically replaced by the House and Senate so they can sign the document.

The second thing is that if they need to push back the date of delivery of the Trust Fund, they should do it. You know, maybe June, July, I don't care, or if they want to tie it to the budget

submission of the president, that makes a good idea too because it would give the Congress a chance to respond with remedial action if there is a big and unpleasant surprise in the Trust Fund. And those days will come.

So with that, thank you very much, Joe, for inviting me. It's been a great pleasure.

MR. ANTOS: Thanks, Bob. I appreciate those comments. You know, on the timing, one of the problems is that you have to pay attention to when you change some due date for something, you have to pay attention to everything else that is associated with that that may not be completely obvious, and in particular, the IPAB determination.

So according to the law, the IPAB determination is supposed to be made by April 30th. And, of course, where did that date come from? Well, it came from the never never land world where April 1st was the date when the other trust fund, Trustees Report.

So, you know, things really ought to try to mesh a little bit together, and if people on Capitol Hill would just look at the calendar, it would help.

Okay, Alice, please.

MS. RIVLIN: This annual ritual of the Medicare Trustees Report requires, as others have pointed out, really hard work and meticulous analysis, and we should all be grateful to the Trustees and to Paul and his staff for their careful stewardship of the public's funds, and their careful analysis of future risks.

Their job, I think, is to be the public conscience. To remind us all that we and our elected representatives have just not faced up to serious problems that have started us in the face for years.

There are a lot of numbers in this report, but, essentially, no news. We didn't just find out that the population is aging, and that a lot of people who were born between 1964 and 1963 are retiring and costing money.

We didn't just find out that healthcare is becoming both more effective, and more expensive at a rapid rate, and that it is demanding a bigger allocation of the budget whatever budget you're talking about, whether it's the federal budget, or a state budget, or a family budget.

And you don't have to be a policy wonk to know that there's a lot of waste and duplication in the American healthcare delivery system. You only have to be a patient or an honest provider to know that.

So what we learn again from this meticulous and number-heavy report is basically familiar. That we are underfunding the HI Trust Fund. Projection's a little worse this year, but as others have pointed out somewhat better than they had been. Although we're not technically underfunding the Supplementary Medical Insurance Trust Fund, spending, is rising, and the draw on general revenues is expected to rise much more rapidly than anybody intended as we move into the heavy baby boom retirement generation period, and that the respite in healthcare spending is probably over.

Now, Keith is right, and others, to mention that we did get a respite. And the projections that we're looking at for Medicare and for the federal deficit are not nearly as scary as they were five or six years ago when we had Simpson-Bowles and others focusing in sort of panicky way on what are we going to do?

The respite in the rise of healthcare costs has bought us a little time to think more seriously about what to do, and we needed that. But the process of Medicare contributing to rising federal spending, and rising debt, or crowding out other spending, including investment in your people and their skills and knowledge, that we need to grow the economy for the future is very present in this report.

Now, given the fact that Medicare is such a vital program, and serves so many people, and is so essential to seniors and disabled people, solving its fiscal and designed problems will take bipartisan effort and consensus action.

And you might think that we're never going to get that in this highly polarized political system, so we won't be able to cope with this challenged. But surprisingly, that's not true of Medicare.

In contrast with Social Security, for example, in Social Security, we've got a somewhat similar but much simpler problem with much less uncertainty. We have a known set of options that would restore solvency, and nothing is happening. The clock is ticking. The delay in fixing the problem is costly, and no action seems to be in prospect.

But Medicare is different. Two basic approaches are available to reining in the growth of costs, and improving quality and effectiveness of care. One is changing payment incentives for providers so they reward value and quality more, and volume of services less. And the other is to let consumer choice and market competition operate to the same end.

And we've been moving slowly in the both directions, and actually quite a lot of bipartisan activity is happening. We have an explosion of experiments with payment reform that are being tried and evaluated mostly with Medicare in the lead. We have experiments with market approaches like health savings accounts. And competition among health plans are on organized electronic marketplaces.

We have this; the big experiment is not yet in Medicare. It's in the Affordable Care Act where we're actually running a huge national experiment in competition on exchanges, and we're learning a lot about how it can work and what its limitations are.

And we've even had bipartisan legislation, including MACRA. I for one would say that whatever the projections, and they are no more certain, Paul, than the projections of the Trust Fund. We're not likely to cut that 5 percent bonus, just cut it off.

But whatever the projections, I would say MACRA is a step up from the SGR because it does focus attention on a strategy of improving the payment incentives, and that's necessary.

I would say we need to pursue both of these strategies more aggressively, or less timidly. We particularly need to give patients more skin in the game if we believe that an accountable care organization, or some other form of payment reform is promising, then patients ought to know they're in it, and be able to participate in, have an incentive to participate in improving the cost effectiveness of their care, and we're not there now.

And I believe we need to move more aggressively toward competition among plans, and quite deliberately, but not too fast toward premium support in Medicare. We could start with competitive bidding in Medicare Advantage, which one of the charts in Paul's deck which he didn't talk about, says is a bigger, really quite astonishingly, a big proportion of Medicare already.

We need to be sure that we can make competitive bidding work and solve the risk adjustment problem so we don't end up as we move to premium support, if we do, with the sickest people in traditional Medicare.

But I think if we do, if we take action, and there is a bipartisan coalition that is working in both, on both sides of the Hill, we could move toward the model of capitated health plans competing with each other on exchanges which I think would eventually slow the rate of growth of Medicare cost, and produce a more cheerful Medicare Trustees Report in the future.

You may notice I didn't mention the IPAB. And that's because I'm a skeptic of the approach of tinkering with Medicare costs on a year-by-year basis. I think we need fundamental reforms of the type that I've been talking about, and that there is a chance of getting them.

Not to be too political, but imagine this. Imagine that after this election, we have two certified policy wonks, one Democrat in the White House, and one Republican in the speaker of the House, who have a demonstrated interest in solving healthcare problems, and who might be able to give us a bipartisan revolution here. Thank you.

Thank you, Alice. More disturbing optimism.

(Laughter)

MR. ANTOS: I really, I like all your points, but I reemphasize your point about IPAB and not tinkering year-by-year. You know, this is fraught with all kinds of danger because you can imagine a situation where the determination is a determination just barely. If the numbers come out just barely calling for action, this is a problem, of course, with formula-based policymaking as opposed to policymaking the way people imagine that it would be.

So we had a formula here, and we could be much like the SGR, much like many things in the Medicare Program, we are at least theoretically locked into a formula, and, of course, if we actually got into that situation, that would propel Congress to make some changes.

Jim, please.

MR. CAPRETTA: Thank you. Pleasure to be here and part of the group again this year. Thanks, Joe, for inviting me. I think I'm at the end of the table here because I'm a little bit of an outliers, and the more I heard, the more disagreeable I've gotten.

So I think a little more disagreement here might spice things up, so I'll do my part to stir the pot a little bit.

First of all, I think the Trustees Report, of course, has its own ~~statutorial~~ statutory obligations. It's in a confined role. But it's part of a larger patchwork of things that have gone on in the last, you know, couple of decades where I think the country is in a sense sleepwalking itself into a major problem. And one can always, ah, these long-run projections, who knows what it's going to be like in 2030 or 2040? Well, candidly, we kind of do know what's it's gonna look like in 2030 and 2040. That we're going to have a lot older population with a lot of demands for health services, and having a realistic expectation about what that's going to entail is crucially important to planning ahead.

We've got all kinds of political leadership in state and local governance in this country, and internationally where governments have gotten themselves into huge, huge problems by essentially sleepwalking into a major entitlement problem.

And if you look back to the early 1970s, the U.S. government was spending roughly 4 percent of GDP on the big, expensive programs. We're spending 10 percent today, including a huge increase in Medicare over that period of time.

And, you know, 6 percentage points of GDP in, you know, 45 years or so, it's a big deal. If you want to know why we have fiscal pressures right now, forget about 20 years from now, why we feel fiscally stressed right now is because Medicare has grown immensely in the last four decades. Huge resources are going into the program that could have been going into all kinds of other priorities.

And, you know, we've done lots of things, and people are doing lots of things, but it has not been enough by far. In the future, yeah, we have a lot of uncertainty about, you know, rates of growth and so on. I'm going to talk about that in a second, but I think anyone looking at the big picture saying, oh, let's think about this for another five, ten, 15 years, you know, how we're going to figure out how to manage our entitlement system, especially Medicare and Social Security, I think they're really just doing the country a disservice because it's, you know, we're well into the retirement of the baby boom, and making changes now for the people that are already on the program it's going to be very, very difficult, or even people that are retiring in the next ten years it will be very difficult. We should have been making changes in the program 20 years ago. And so we're a little late already.

The second thing I'd say is that this optimism about where we are, and the long-run projections I think is really entirely misplaced, and really kind of papers over sort of what's going on here.

Two laws have passed, the Affordable Care Act, and MACRA last year that, essentially, took the approach that been applying in Medicare for a very long time to its logical conclusion, which is that it said, you know what, the way to solve this problem is essentially pay everybody less. Brilliant insight, right?

And so what they did was they wrote into the Medicare Law that says, lot of people understand this. This is one of these technical things and sort of written, you know, in the acronyms and code words, but basically said we're going to say to all the major facilities providing services to Medicare patients that you're expected more productive every year at about 1 percentage point, which is roughly what it is economy side, and we're going to pay you less every year based on that. We're going to reduce your update for medical inflation based on that productivity adjustment. And then they just ran it out for 75 years and said, you know, that's the way it is.

Now, if solving, if the problem with healthcare was, you know what, we just needed to pay everybody. Remember, this doesn't apply any kind of quality metric or anything else. It just say to everybody in the whole country, hey, you're going to get paid a lot less.

Okay. Great. And then in MACRA, they essentially did the same thing. They basically just said forevermore, physicians who try not to go into the alternative payment models are going to get .25 percent inflation increase in perpetuity. I mean, who believes that? Right? I don't believe it. Okay

And so I think there's an element of unrealism about all this that is, it's very cleaveclear. It's a papered over this massive problem, and it's basically adding to the sleepwalking. And I think there's a problem.

Now, back to MACRA, I mean, I just had the one, Alice mentioned that, you know, it was a big step forward. I think it's just a gigantic illusion, frankly. It, basically, said that the federal government is going to rank every physician in the country on a quality metric beginning in 2019, and the pay them accordingly based on their score.

I don't know. I just, call me skeptical, but the idea that the federal government is going to do this in way that people will accept, I think there's zero chance that that will happen.

The physician community, or, frankly, the public at large is going to trust the federal government to do this right. So there's some fundamental issues associated with MACRA that will, I, you

know, I've been surprised about many things in the last year, but maybe I'll be surprised again, but I really think the MACRA thing is headed toward a massive revision at some point.

And then my last point, because I think I stirred the pot enough probably, is really to the question of the fundamental issue which is how do you achieve productivity growth in the health system?

I think both Keith and Paul have sort of hinted that, well, if you just lowered the prices as you did for the productivity adjustment maybe the hospital systems will have to adjust. They know they're going to get paid a lot less, and, therefore, they're going to have to become more productive. That's one interpretation. That's possible. Okay. But there's lots of literature around payment systems that show it reduces quality as well. So that if you just reduce the price of something, it tends to be if productivity can't go up, then the quality goes down. It's a definitional thing. It's not a political point. It's a definitional thing. Okay. If the productivity doesn't go up, the price is reduced, by definition the quality goes down. Okay.

So, you know, I think it can be hidden and people won't realize it. It'll be very subtle, but I think people should understand that's sort of what's potentially at stake here.

And then to step back from it and say what would actually really improve productivity over the long run, the medium and long run, I think really that is the choice. So you have this mix of things going on as Alice indicated. You've got the federal government through CMMI and all these payment reform projects trying essentially to raise the productivity of the medical delivery system through payment incentives, regulatory changes, trying to nudge and push the delivery system to operate differently than it has in the past, and, perhaps, that can make some marginal improvements over time.

I wouldn't get though that a regulated, you know, moving the delivery system into a regulated models over the medium and long run, is going to result in higher productivity than a truly market driven approach.

The idea that, there's evidence that a regulated approach can improve productivity over the medium and long run relative to productivity improvements that are coming about through strong incentives, through consumers making choices.

So I do think that's fundamentally, you know, what's at stake in all of this, and I certainly appreciate that the Trustees Report gives us an opportunity every year to raise some of these things and

talk about some of these things. I think, unfortunately, it's done in such a, in a context in these years that I think is lulling a lot of people to sleep. Thank you.

MR. ANTOS: Thanks, Jim. Your remarks to me emphasize the difference between passing a law and living with it. As hard as it is to pass a law, it's usually much harder to live with it. And Congress has demonstrated time and time again that they won't live with it.

You know, the fact is that IPAB and these productivity adjustments were put in to get a budget score. But a realistic person would just look at the recent history of the Medicare Program and come to the conclusion that, you know, everybody breathe a sigh of relief, same with MACRA, we got that take care of, and we'll leave it to some future congress to solve the problem that we have created in finding a solution that won't work. I hope that's sufficiently negative.

Well, I'm sure people have comments back and forth, and so let's--

MS. RIVLIN: Can I help on your being sufficiently negative?

MR. ANTOS: Please.

MS. RIVLIN: I don't think any of us who said that MACRA is an improvement over the SGR. Thought it was the magic bullet that was going to solve everything as you've just implied.

I just think it's a better starting point. It does emphasize that we need to increase productivity in the healthcare deliver system, and that incentives may have something to do with that. I don't think that's all inconsistent, although Jim apparently does with consumer choice as with competition among plans on exchanges which I'm also for.

MR. CAPRETTA: I would just note that the way, (inaudible) you don't know, the way the MACRA works is it essentially says if a physician is getting paid through the traditional fee for service model they'll be in this things called MIPS where they get the potentially small bonus payments, but a .25 percent increase in their physician fees over the years, but if they go into an alternative payment model, then they get the .75 and potentially large bonus payments depending on how that works out.

The realistic scenario at this point is there really isn't an alternative payment models that are big and viable except for the ACO Project that the administration launched as well. And so what's really going on here is you have -- remember on the ACOs, how does the ACO work?

The ACO says that the beneficiary actually doesn't really overtly select, join the ACO. It's like a managed care plan without the insurance component which is what they want. They hate insurance companies, right, so they say let's have managed care between hospitals and physicians working together, but we're not going to have an insurance component to it, and beneficiaries will be assigned to them based on the physicians that they go to see. Okay.

So the beneficiaries are allowed at that point to opt out if somebody tells them. Okay. But, basically, if you surveyed the beneficiary population, most of them have no idea they're in the ACOs. Okay. So it's not a beneficiary choice process.

Then the MACRA layers on top of it and says, by the way, we're going to kind of jam the physicians into the ACOs because that's the only way they can get their payment rate above .25 percent every year. Okay. So it's sort of coercion in two directions to try to move the beneficiary population and the physician population into the ACO project.

If you can't see that that's what's going on, that's what going on. Now, will it work? I mean, you know, if you look at the ACO Project so far, I think the results are, you know, let's say spotty. That's the best way to put it.

MS. RIVLIN: But that's why I want to change it. You just made the speech for me.

MR. ANTOS: I have a quick comment on this whole business about the ACO. One of the thing that hasn't really gone well is that the Innovation Center has been initiating numerous projects without really I think being able to consider the overlaps. So there's very good paper by Rob Mechanic -in a recent addition of the New England Journal of Medicine that illustrates this. That the (inaudible), for example, can undercut the potential for gain sharing, basically, profit sharing from the ACOs, and that would then dampen the interest in ACOs. It's a complicated argument, but it's fundamentally correct. We have a lot of things going on. In many cases, providers are trying to participate in more than one of things or are required to participate in more than one of these things. And it turns out that without clear incentives, you have muddled reaction.

The other point that I would make is that what is-are the changes that have ~~to-be, have-to~~ actually occur? It's not in the government. The government could facilitate or can impede that change,

but the change in delivery system has to be with the delivery system. Has to be down there not, we can facilitate it or not, but there has to be a reason to make changes down at the business level.

MR. MOFFIT: I just want to emphasize something that I think we all have to keep in mind when we talk about the Trust Fund Report. I sympathize with Jim's view on this. I think that we are sleepwalking into a fiscal crisis. I believe that. ~~I that.~~ I think he's absolutely correct on that.

But I think the Medicare Trustees sometimes quite like the CBO will state things in ways that are somewhat soporific. I mean, there's no question about it. I mean, this is not, this is bedside reading if you have insomnia, and you really want to go to sleep, you know, by the time you're on page 60 of the Trustees Report, you're starting to nod.

But in defense of the Trustees, they actually state really dramatic things. Now, I just mentioned one in response to my colleague here, Keith Fontenot, says the ACA is working. I don't think the ACA is working. But if the ACA were to work, the Trustees are telling you that 50 percent of the hospitals in the United States are going to be in the red, and that is going to threaten patient care. Excuse me. It is not neon signs. It's not; people are not screaming and running around in the streets as a result of what, of the issuance of this in the past 48 hours, 24 hours, but its real stuff.

The other thing I want to mention is that despite the fact that it is a very, they're very measured. Okay. On page 4, they state in terms of the stratus of the trust fund and the growth in Medicare spending, there is an urgent requirement for remedial action. "Such legislation should be enacted sooner rather than later to minimize the impact on beneficiaries, providers, and taxpayers."

Now, they've been saying this for years. The problem is members of Congress who authorize all this, they're not either reading it, or if they are reading it, they're ignoring it.

They have done their job. The Trustees have done their job. The public officials on Capitol Hill and elsewhere, including the Administration, it's really time for them to do their job, and they're not doing it.

MR. FONTENOT: Let me take issue with a couple of things here a little bit, and then I think we should drag Paul back in because this is ~~suppose to~~supposed to be more about the Trustees Report. We're kind of going off in a little bit different direction.

The first thing I would say is there isn't a magic bullet. You can't just snap your fingers, fix this program, and have it run on auto pilot for 80 years. American society changes, demographics change, people change, medical technology changes, delivery systems change, and were morphed from a UCR, you know, cost plus payment system into all sorts of managed care.

We're doing what Americans do. We're trying different things, and we're working out say through. I don't think necessarily throwing it all into the market and the premium support system is the answer either.

But I do think, I agree with everybody in one fundamental way, which is there is a problem coming and we need to be doing something about it. We don't need to go helter-skelter off the edge of cliff, but we should be really working on that.

And I guess I asked the question where does that start? It really starts with a political consensus around the need to do something which we don't seem to have in this country. And I wish I could change that, personally, but I don't know how.

If we could get there, and I'm probably a little less optimistic than Alice about the possibility of getting there, but I'd like to think that that could happen that there would be some possible rapprochement.

I'm more feared that, you know, there's certain elements of the caucus if the House stays in Republican hands would keep it in a different position. I hope it changes, but I hope it doesn't change as a result of some crisis. I mean, in a larger sense this not just about Medicare. It's about the balance of taxes, spending. It's about discretionary spending. It's about everything else, and I think we have to quick a lot of this debate which is so large back into that kind of context because I don't think is a problem that will be solved simply by cutting spending everywhere. You have to look at the tax system too for the simple reason that, you know, the demographic of this country really have changed, but we need to get the whole thing under control.

I'd like to come back to sort of one point that was made. You know, we talked about IPAB in various ways, and maybe it triggers, maybe it doesn't, but it did don one thing which is I think

people actually are looking at those growth rates in a very close way, and I think that's good because if something spikes or changes, you know, if there's an intention paid to it, that is salutary.

Now, there's no issue this year that triggered this year. It's been a little messy because of the change in administrations. And we'll see what happens next year. But the question will become is it because spending was low one year and higher the next which should factor into a determination about what you do, or is there really an underlying trend? And that's what I think this kind of analysis really helps you do.

I agree about sleepwalking. I mean, I think that fundamentally we've, I've been working on this stuff for 30 year plus now, and last time I did Social Security reform, we were in a crisis. The benefits were just about out of, was just about out of funds to pay benefits. And we got through it as we do uniquely in American way.

We do have time to think about this and about really, I think it has to be thought about in our overall fiscal context, and you have to put all the kinds of things on the table, revenues and spending. Because I think fundamentally when you look at the balance of what Americans want from their government, and then what they're willing to pay to do it, we have to look at those issues too.

MR. ANTOS: And there isn't a Medicare program to borrow from. That's what saved Social Security in the eighties, and there's no more, no more money to be borrowed.

SPEAKER: Well, that was the short term. Then there was a larger fix called the 1983 Social Security --

MR. ANTOS: No, no, no. Right. Right. But--

SPEAKER: Which haven't lasted forever, but it has gotten us, what, 30 some odd years out.

MR. ANTOS: And it pushed it, I mean, one of the key --

SPEAKER: Yeah.

MR. ANTOS: I mean, one of the key characteristics was that it wasn't instantly implemented. It was put off.

SPEAKER: Yes. I agree with you completely on that.

MR. ANTOS: Yeah.

SPEAKER: I think if we can find things that we can phase in over time and somewhere that that a really good way --

MR. ANTOS: It's a better way to do it. Sure.

SPEAKER: Well, just as the objective, nonpartisan in the room, I think we're talking all, everyone's really talking about the same issues. That's the current trajectory of both the Medicare Program, and how we're financing healthcare in the country more broadly is an area that needs to be addressed, and needs to be fixed.

And I think there's a whole host of initiatives, and a whole host of proposals out there to attempt to do so. I think some of the current approaches towards shifting the incentives of the program from paying for quality, paying for quantity to paying for quality is certainly laying the groundwork, and certainly a good first step there. We're going to have to see how all that's going to play out

In terms of one thing I wanted to respond to just we currently, the Centers for Medicare and Medicaid Services currently ranks all of the Part C and D plans out there, and their payment is very based on that ranking. So there is a model out there. It's, obviously, you know, would have a much larger reach when historically affecting physician payments, but there is current program out there where, where CMS, the government as it was characterized, is determining, is ranking, is ranking plans, and adjusting payments according to those rankings. So that is something that exists today.

MR. ANTOS: Unless there are -- yeah, a question. Let's move to the floor. John, let's start with you. Well, let's wait for the microphone because the online audience wants to hear this. And please identify yourself, your organization, and then ask the question.

MR. ROTHER: John Rother. I'm the CEO of the National Coalition on Health Care. So I have two comments and two questions for Paul.

The comments are, number one, I really want to second Bob and his view that in a way, the focus on the Trust Fund is misleading. The big problem is healthcare costs generally, and the burden on the economy and the Trust Fund focus is easily solved by transfer of general revenues, and the larger problem then would be unaddressed. So I really think that it's important to move away from that.

The second point of the comment is this discussion assumes that IPAB exists. To my knowledge, it doesn't exist, and so I'm not sure it ever will. So in a way, that's kind of a hypothetical.

But I do have two hypotheticals for Paul that I think maybe illustrate both the optimistic and pessimistic view. The optimistic hypothetical is more and more people enroll in capitated integrated plans, and hospitals, therefore, have an incentive to reduce their census as opposed to the current incentive to keep the beds filled.

I think there's quite a bit of room to reduce the hospital census and move care to outpatient settings. So my first question is would that in effect have a big impact on the projections of the program?

The second question on the other side is there's a lot of work going on in the pharmaceutical sector on Alzheimer's, pick one. Suppose we have a pill that is effective for Alzheimer's that costs, I don't know, 20,000 a year?

How can the program possibly accommodate something that every American would want to take advantage of? It just seems to me that we have some bigger challenges ahead of us than those related to the Trust Fund. So if you could comment.

MR. SPITALNIC: Certainly. I agree there are many challenge across the entire program and the health sector arch.

To your two specific points, just on the inpatient shifts, I mean, that's something that's been happening for a number of years where we have seen declines in the rates of inpatient stays. Having done a lot of work to attribute that to the exact rise in managed care more recently is attributable to a larger gaining of coverage throughout the population as a whole as a result of some of the Affordable Care Act expansions.

So there's a whole host of things there. And just the two pushes and pulls, I'm actually surprised weren't mentioned as the panel spoke, that will also greatly affect this is just consolidation.

So consolidation both on the provider side, and on the insurance side. And so as there is a basically a race to see who's going to have the most leverage in these future negotiations, the NODs are just getting larger and there's just more and more ability for, you know, fewer players to be controlling

larger segments of the markets. And as these larger players have to be negotiating against each other, it's still too early to know exactly what the implications of that are going to be.

On the drug side, we've seen numbers of issues, a number of issues on the pricing of new prescriptions. You know, the hepatitis C of the recent several years is just, you know, the most dramatic example of what's happened in the recent past, but we're seeing it in other, for other conditions as well.

As new drugs come to market and address these larger issues, there is going to be the demand. And when we see a demand, we're going to see the pricing on it. And in Part D in particular, less so on in the Part B setting is drugs that are administered in physician's offices.

But certainly, drugs that are administered through prescriptions generally received through pharmacies, or through what have you, that's currently having an effect on how the Part D benefit is being priced and delivered. And as we see more and more use there, the prices, basically, the level of catastrophic, the share of the benefits that's going toward catastrophic spending is rising which means that the broader benefit is actually minimizing.

And so as we see that continue to emerge, and that's been a trend over the last several years, not just in response to the hepatitis C drugs, but even started before then, is just a dramatic shift thereafter, that's a problem that will continue to be monitored.

You know, when you have this, you know, this miracle drug that's, I think you have a better sense for how any of these future drugs might be priced. It's still not obvious to me how some of these things get priced.

But we're seeing what the trends are, and the trends are that as these new treatments are coming to market, they're coming to market at higher prices than they've done in the past. Some of them are able to do things that, you know, prior treatments weren't able to do, and you actually would expect to see some savings on some of the inpatient care, or some of the physician care.

To the extent, you know, I'm sure we're gonna see less liver transplants in a few years in response to some of the hepatitis C (inaudible).

MR. ANTOS: Does anybody else want to make a comment?

I have a clarification on the IPAB. You don't need the actual board. The authority is vested in the secretary. So, in fact, there probably will never been a board. But it doesn't matter. That makes the secretary in charge, not Paul, but as he said, he merely provides the numbers, but the whole rest of it would go forward at least in theory.

Now, we'll see if Congress can actually deliver that. But we need to have, yeah.

MS. DELLOW: Hi. My name is Barbara Dellow, and I wear many hats, one of which is being a home caretaker for my dad 24/7.

I appreciate your economic concerns and the need to look at things like premiums, transfer payments, and reassessing economic priorities. Yet, the current Medicare focus on cost savings side by side with a push for care management, end-of-life forums, and passage of assisted suicide law reflect diminished value for the frail and elderly in our society.

Will there be protections in the Medicare system, and political will needed to insure needed care will be available for those with disabilities, or diminished life expectancy?

MR. SPITALNIC: Again, I'm just the actuary. So I could say that there is a firm commitment from, you know, that of running the agency and the Department to addressing exactly those issues. I mean, that's, first and foremost the concern, the focus of what's, all of the development around different policy initiatives around what's happening in the program, really go back to what's called the triple aim. So can you get, you know, better patient experience? Can you get better health outcomes, and can you control costs?

And so while different factor of those might be emphasized, that's really what's driving the work of the administration. And we can certainly have disagreements as to how well, they're doing in any one of those area, but that's certainly how, that's certainly what's directing the work.

MR. ANTOS: The other thing is that the kinds of services you're talking about, is this not strictly a Medicare issue? This is also a Medicaid issue, and it's a family issue. So the idea that somehow the government would have fully paid benefits in every conceivable dimension is, has never been true, and is never going to be plausible.

So there's a lot of responsibility all the way around, but it's not solely a Medicare issue.

I know I saw some hands back there.

SPEAKER: Good morning, everyone. My is (inaudible), and I'm a law professor at the Center for Health Law and Policy at Cleveland Marshall School of Law.

This is a question to the CMS Actuary. I notice in your presentation today, and in the 2015 Report that when you do the chart showing what the Medicare spending is, and what the target is, the trigger for IPAB determination is 2017. And then it changes and there's not a requirement for the next couple of years, and then in 2022 it looks like going forward there is a change. What's the basis for that stop and start?

MR. SPITALNIC: The biggest basis of the difference is that the method for determining what the target is changes. And so for, it's I think, through 2017 the basis of that target is equal to the average of the CPI and the CPI medical. And then starting in 2018 and later, the target is GDP plus 1. And so that the largest difference for why there is such an increase in the target determinations.

On the Medicare side, as was mentioned earlier, we're currently experiencing historically low growth rates. The expectation and the expectation in the Trustees Report are that those growth rates are going to return to more like historical levels, not quite all the way to historical levels, but get closer to there. So there is going to be that steady increase on underlying costs growth. We're not going to stay at historically low levels forever, and so we're going to return back to more typical levels.

So you've got the gap in 2018 on the determination, on the target side, and you've got the gradual, more gradual increase on the Medicare cost side.

MR. ANTOS: You know, I'm a little curious. Does anybody have any idea what the thinking was for having these two different targets? Alice, do you know what they had in mind?

MS. RIVLIN: I think it was just a political compromise, but the question of at what rate can medical spending grow sustainably over time does, I think, have to relate to the GDP, or per capita GDP, and some of us argue for in the long run, we don't want medical spending which is already 18 percent of GDP to grow faster than the GDP, but that's too ambitious a target to get to quickly, so they said GDP plus 1.

MR. HELLMAN: Hi. Paul Hellman Simpson Partners. And this question may be a little bit in the weeds even for the actuary, but --

MR. ANTOS: Finally, we're getting to the real stuff.

MR. HELLMAN: I warn you. And maybe better than some of your comments already. But if you look at the IPAB table, there is a sharp drop off in comparison to your estimate a year ago in 2017 per capital spending growth, and I'm wondering why that is. I get the slowing trend, but it's like a one-year drop. What's driving that? And then it just jump right back up to what basically what you were saying the growth trend would be on a per capita basis a year ago.

And then on another table on Part D, there is a surge in the drug spending on a per capita basis and on an aggregate basis in 2018. And I'm wondering you know what the cause of that is.

MR. SPITALNIC: (Off mic). And actually both the answers are actually related. So one thing that did happen since last year's report is that there was the delay in the, or a postponement of pause of the health insurer fee for 2017. So the expectation is that there will be the health insurer fee, which is part, which is paid for by both Medicare Advantage and Part D plans basically will not be made in 2017. It's only postpone for one year, so 2017 you see a drop. 2018 you see a spike up to basically account for that.

So that's actually largely why those two years you see you basically end at the same place, but you see the little spike there.

For Part D, you have a similar story, but on top of that you also have just a general slowing of the rate of brand expirations and generics coming on board. Those two are directly related.

MR. ANTOS: Thanks. Any other questions? Yes, up front here, please.

SPEAKER: Thank you for this panel. I'm actually a graduate student at UNC Chapel Hill. I am studying health policy. And I just have a question for Mr. Capretta. You mentioned that the alternative that might work would be a consumer driven market, truly market driven approach to health care, and I was wondering because right now we have a very fragmented health care system, and going through especially people with chronic illnesses, I also volunteer as a care manager, and, you know,

connecting the different, I guess, chronic illnesses, it's difficult for the patient, and it's also even with our health literacy that's also a problem.

And so I was wondering what kind of suggestions you have when we have a truly market driven system.

MR. CAPRETTA: It's a good question. I would say that the competition that we need to move toward is over both the premium that people pay for the coverage they're getting, but also the delivery structure that gets attached to it. Okay. And so that would mean in the Medicare context that people decide in advance probably years in advance before they're facing some of these eventualities that they pay a premium to a plan and the here's how that plan will handle providing for a chronic condition that last over a number of years, and they opt for that because of its combination of price and quality.

And I think that's sort of what we're trying to get to in a lot of way. I agree with Alice's movement in these directions, but I think it needs to be accelerated, and there needs to be much more of an emphasis on it.

And just back to the point about the ACOs. I'm not against, and I think Alice may agree with this, I'm not against the concept of people enrolling in an ACO. If a beneficiary wants to do that, I think that would be a fine option. I think what we should do is present these options clearly and transparently to the beneficiaries and let them and their givers and family members figure out if that's going to be the best way for them to get the care they need.

I'm a believer in integrated care. I think we have a fragmented, expensive, costly system, and I think it's proven that if you have well run integrated care where people are using data to improve care protocols over time, lots of waste could be driven out of the system.

What I'm not a believer in is essentially CMS trying to be the driver of integrated care in the United States. I think that's a recipe for a lot of mistakes along the way.

MR. ANTOS: Okay. Well, any other questions? Any other comments by the panel? Oh, there's one more. Okay.

SPEAKER: Good everybody. My name is (inaudible). I'm from the Better Medicare Alliance. I had a question actually about IPAB (inaudible).

The Board if it's convened, if you hit the actual benchmark, the actuarial one. 15 persons are meant to be put into a room for God knows how long with the door closed and the figure this out.

That has to go through the Senate for the consideration for nomination. If they are unable to do that, and I can say personally I -- it's a toss-up. Maybe they do. Maybe they don't. Whatever might be?

If they do not nominate, or they cannot give consent for 15 nominees, where does the Secretary have their inclination for cutting what might be a 0.2 percent difference, and where are sort of the target one, target two, target three versus, you know, anything else down the line? What might be the most probably areas to make up that difference? Thank you.

MR. ANTOS: Well, I have (indiscernible 19:23:18:) about that. Given the schedule that the IPAB or the Secretary have to adhere to. It has to move very quickly. So what's the quickest thing you can do in Medicare, and that's cut up date factors.

So it does not represent and improvement in the structure of healthcare delivery or the structure of financing because even coming up with a new payment system takes more than the amount of time that's going to be available unless you've been preparing for actually quite a few years.

Now, as far as where they're going to cut, the Kaiser Family Foundation did a report, and I don't remember all of the details, but they did say that the Medicare Advantage Program was going to be probably more targeted than other places because they're are, at least initially, ~~there are~~ some restrictions about what the IPAB can theoretically do. Basically, anything that would directly, in some sense directly affect beneficiaries is supposed to be left alone. It's sort of odd language, and maybe Paul remembers or somebody here remembers the exact language.

But it really narrows out the range of possibilities. Also, I think the services that are affected by productivity cuts also are --

MR. SPITALNIC: Anything that was reduced by an amount in excess of the productivity -

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MR. ANTOS: Okay. -- through 2019. Correct. So initially it's very, very restrictive, and then after that I'd say anybody's guess. But again, given that the schedule is really a one-year schedule, it's really hard to imagine anything sophisticated coming out of that.

Go ahead, Bob.

MR. MOFFIT: You know, I'd like to follow up on that because I think you've raised a very important point. This actually when IPAB was created, Peter Oszag, the president's former director of the Office of Management and Budget, referred to that provision of the Affordable Care Act as one of the most important provisions of law as a mechanism to control future healthcare costs.

He also said something else, and I, frankly, being a political scientist am much more interested in this, part two. Which is he said in his experience, it was one of the greatest transfer of sovereignty from the Congress to the executive branch of the government.

That is why you've had an unlikely alliance of Democrats, including very liberal Democrats like Frank Pallone of New Jersey, and previously Pete Stark of California, allied with Congressman Ryan in opposition to this institution because it's a really, it really is exercising, in effect, a legislative authority that Congress should exercise.

There is, I think it's certainly true among Republicans, but I think institutionally behind closed doors, a lot of Democrats in Congress are thinking, have we given up too much authority to the executive branch largely because of the experience we've been having over the past several years with independent executive branch decisions some of which are not connected with statutory authority at all.

With regard to IPAB, remember this. IPAB actually is in one sense a very crude thing. It is basically the ultimate blunt axe for controlling costs. The only thing the institution can actually do, the only thing the Board can do, or the Secretary can do is basically reduce provider payment. They can't really do too much else beyond that. They cannot, for example, the law is very clear. They cannot ration care, at least explicitly. They cannot increase taxes. They can't change the benefits of the beneficiaries, or their eligibility for coverage. They can't increase beneficiary premiums, increase beneficiary cost sharing, reduce subsidies for low income beneficiaries.

So, in effect, you know, this is properly a controversial provision of law. I don't think it will survive.

MR. ANTOS: Well, unfortunately, we run out of time so we can argue with each other off camera. Thank you. Please join me in thanking the panel for a terrific discussion.

(Applause)

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