Chapter Seven

We Can’t Allow Government-Funded Health Care To Cripple our Economy

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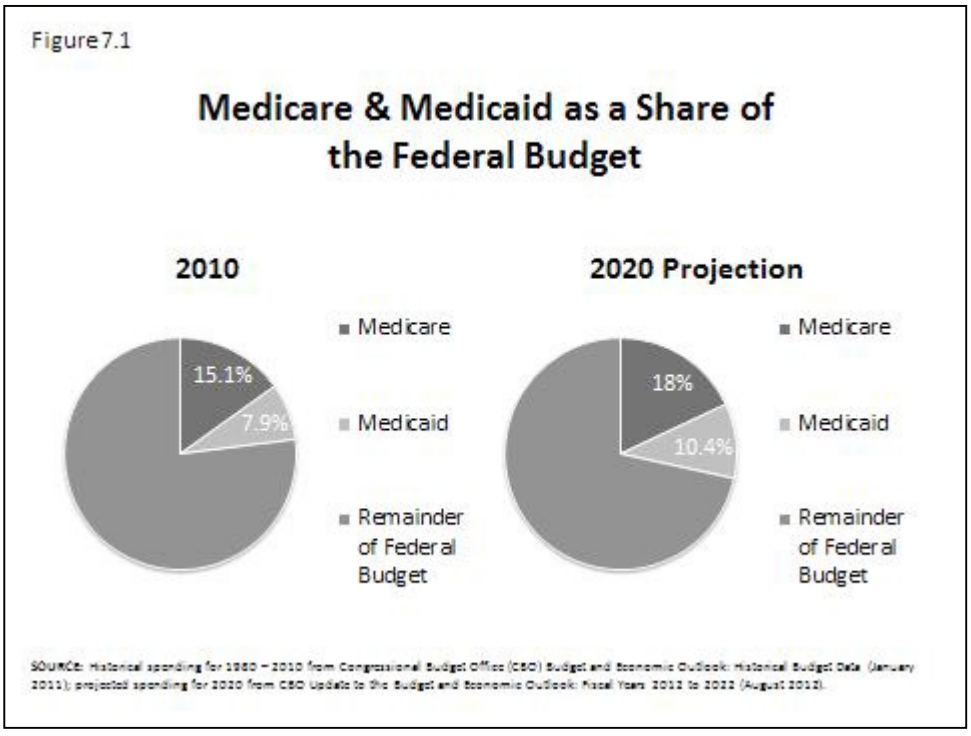
We really cannot afford to allow the health care costs that are being incurred by our Medicare and Medicaid programs destroy our state and federal budgets and seriously damage our economy. That is the path we are on today. It is clearly the wrong path to be on.

The biggest strains and the biggest financial burdens for our state and federal budgets are currently the cost increases that are projected for those two major government-purchased health care programs. Medicare and Medicaid expenses are literally squeezing other key functional priorities -- such as education and infrastructure repair -- out of our governmental budgets at multiple levels.

We should not allow those projected spending increases to happen. We should do sane and reasonable things to restrain the rate of growth in both programs and we should hold those expenses to levels that do not destroy our budgets.

This pie chart below shows the projected impact on the federal budget of both programs for just this decade.

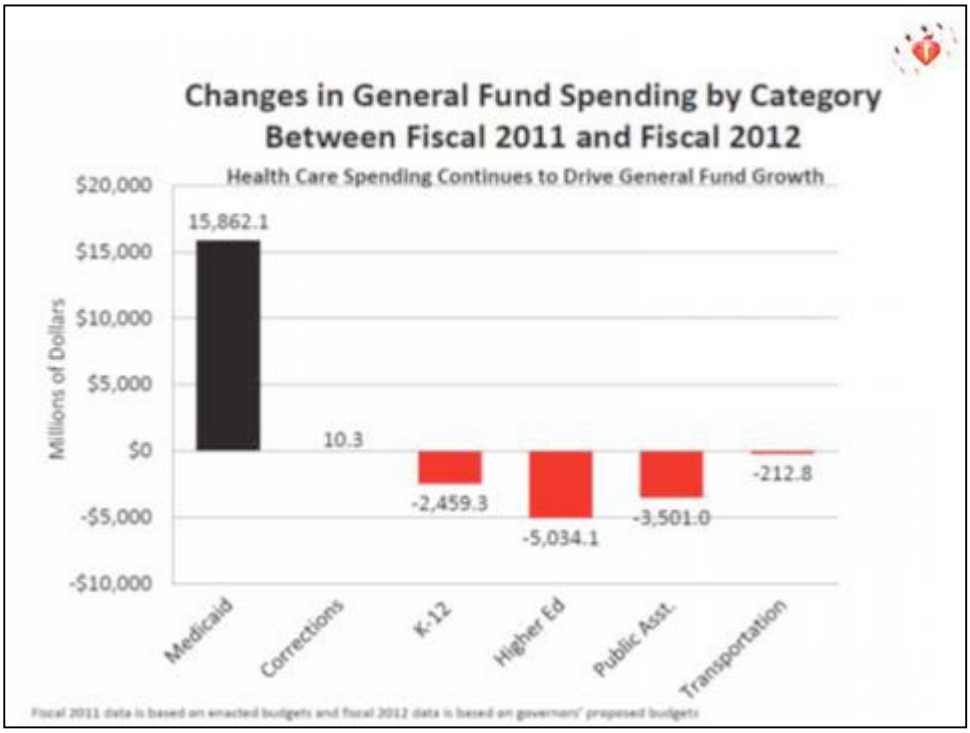
Figure 7.1



SOURCE: Historical spending for 1980 – 2010 from Congressional Budget Office (CBO) Budget and Economic Outlook: Historical Budget Data (January 2011); projected spending for 2020 from CBO Update to the Budget and Economic Outlook: Fiscal Years 2012 to 2022 (August 2012).

Medicaid is not only a major federal government expense -- it is also the largest single expense item in most state budgets.

The next chart shows the impact in state budget spending levels that happened a year ago because of increases in the state Medicaid budgets. As you can see, Medicaid spending grew at the expense of all other major categories of spending.



It is not a good thing to spend that much taxpayer money on healthcare. It is not a good thing to have health care costs eating up other governmental programs. The truth is -- we can do better. We can take steps that will reduce the projected rates of increase in both of those programs and we can improve the effectiveness and the quality of the care delivered by both programs at the same time.

It would be bad enough if we were paying those growing health care costs with current tax dollars. The truth is, we are actually borrowing money as a country to pay some of those health care bills.

Using debt financing to pay for current health care costs means that we are using health care services for ourselves and for our fellow Americans today and then we are simply sending the bills for much of

that care into the future to be paid by our children and our grandchildren. Our children and grandchildren will literally need to pay taxes in the future to buy our care today. Their paychecks and their bank accounts will be reduced by those taxes.

Spending their tax money to pay for our current costs of care will prevent them from being able to use using their own tax money to deal with the actual issues that they will face themselves at that point in time. That is not a good thing to do to our children and grandchildren. We need to do sensible and reasonable things now so we can to spend less money on those programs today and not have to borrow money to buy that care.

We should have the insight, the skill, and the political courage to deal effectively with health care costs today. If we can't reduce those costs today, we should at least decide to simply pay for today's care with today's tax dollars. We have two fully ethical choices about how to avoid creating that debt burden for our children. We could avoid that burden by raising taxes today to pay for that care with our own money, or we could avoid borrowing that money by cutting costs. Both of those solutions are preferable to the path we are on. For us to duck, avoid, hide from and ignore difficult issues today relating to health care costs and for us to choose instead to have our children use their future wages and earnings and their future tax cash flow to pay -- with interest -- for our current care is not a good thing to do. We should be apologizing to our children for making that choice. We definitely should stop doing it.

The very best way to stop using their money to pay for our care is to do the things now that are necessary to bring today's costs for those major programs down to the levels where the costs can be funded with today's dollars.

Debt Financing Can Be an Intelligent Strategy for the Right Expense

That is the key message of this chapter.

The point being made here is not that debt financing for government expenses is inherently a bad thing to do. Debt financing can be a very good thing to do. Speaking as a business head who has been

the CEO of one functional, operational and successful multi-billion business or another for more than three decades, the pure business truth is that debt financing can be a brilliant thing to do. Businesses use debt financing all the time in very intelligent ways. Businesses that need capital can use debt in highly productive ways to build factories, to buy stores and expand work sites, and even to train workers. Businesses that have been managed by the author have literally borrowed multiple billions of dollars over the years. Raising money appropriately through debt financing can make wonderful practical and functional sense for a business. If the borrowed money is used wisely and used well, that borrowed money can significantly increase, enhance and improve the future success levels for a business. The factory or the hospital that is built today with borrowed money can allow the business who borrowed the money to build the products to sell and deliver the services that are needed to be a successful business far into the future. Smart debt can be a good thing for a business to do when smart debt improves future success levels for the business.

Likewise, when governments use debt financing to build streets, roads, power supplies, schools, and to create appropriate workforce availability -- and when governments use debt financing to buy expensive and durable pieces of long lasting functional and operational equipment and infrastructure, the future functional gains that result for society from making those kinds of investments can make debt financing a very legitimate and desirable way for the government to create and channel cash flow. That money can be used in very productive ways to good purposes with legitimate results and with valuable returns and consequences.

Building a Bridge With Borrowed Money Can Be a Smart Thing To Do

In a nutshell, borrowing money as a government to build a needed bridge can make great sense. The new bridge can improve societal and economic functionality today and the actual bridge that is built today can extend that functionality far into the future. It is clearly both fair and

appropriate to use debt financing mechanisms to transfer some of the cost burden of building a bridge to future generations of taxpayers because those future taxpayers will also get good use of that bridge.

We Are Not Using That Debt Money To Build Health Care Bridges

That approach to debt makes significant sense. It is a fair and practical way to think about debt. That is not, however, what we are doing with our current debt financing for health care services. We are not borrowing money from the future to build the functional equivalent of a health care bridge. Borrowing money as a government and incurring significant levels of long term governmental debt to generate the cash needed to pay off current situational, incidental, ephemeral, transitory and entirely transitional health care costs for today's patients is a very different thought process and a very different financial equation than paying with future money to build a bridge. We should be very conscious about using the money raised by future taxes to buy things that the future taxpayers will not benefit from in any way.

We Do Not Need To Spend This Much Money on Care

Using debt to finance today's care is particularly inappropriate when we are actually spending money today on care that we do not need to spend on care. We are spending too much money for the care we are buying today. Using debt to finance excessive and unnecessary current spending is operationally inept. We need to address current costs. Current costs should be reduced. We should be spending less money on today's care.

Can that be done? Yes.

The truth is, there are multiple alternative strategies that we could use now to cut current health care costs for both of those major government programs to spending levels that do not require us to pass our current care costs off, down, and on to our children. Unfortunately, we have chosen -- for what are often short term political reasons -- not

to look closely and seriously at those approaches and at those cost-mitigating strategies.

Care delivery will actually benefit from Medicare becoming a better purchaser of care if the purchasing process that is used is well designed, stable, predictable and set up to support care improvement rather than penalize caregivers for making care better and more effective.

The Strategy Will Need To Satisfy CBO Rules

The Congressional Budget Office is the official scorekeeper for the costs that are either projected or reported for any given legislation or regulatory approaches. We need a strategy that will be scored by the Congressional Budget Office (CBO) as achieving the goals we want to achieve or the plan is irrelevant.

We also very definitely need to turn the providers of care in this country into allies for this approach rather than enemies. We need to make some politically challenging decisions now that will actually control the cost of care today and we need to do that in a way that providers of care can benefit from the new approaches. The good news is that we should be able to achieve both of those goals. We need to build a model that will have the infrastructure of care evolving to take advantage of new opportunities rather than mobilizing to resist changes in their basic funding. To get the needed levels of provider support, we basically will primarily need to do what this book recommends at multiple levels and that is to move away from buying care only by the piece and put in place approaches that will purchase care for Medicare patients more by the package... and we need to do that in ways that will allow caregivers to benefit from that financial model.

This book has pointed out repeatedly that the business model we use now to buy most is primarily driven by the collection of fees. Business strategies for caregivers who treat Medicare patients today focus on optimizing volumes of those fees. And care for fee-for-service Medicare patients today is limited almost entirely to the specific pieces of care that are included on the Medicare fee schedule. We need the business models for the caregivers who treat Medicare patients to be

focused on approaches and care delivery processes that will make care outcomes better without being handicapped by that piecework business model for buying care. We need purchasing approaches that can both bring down care costs and create financial benefits for caregivers.

Two Funding Tracks for Medicare

To achieve those goals, this book proposes that we now should set up two funding models and tracks for Medicare. One track should build off the current Medicare Advantage (MA) program. The second funding should continue to pay non-Medicare Advantage caregivers directly from Medicare -- but track two should build heavily on the new ACO, medical home, and bundled packages of care that Medicare is learning to use to buy care.

Both tracks of Medicare funding that are proposed in this chapter can and should help make care better for Medicare patients. The Medicare Advantage channel for cash can be set up to encourage the Medicare Advantage plans to work even more closely with their provider networks to improve the quality and affordability of care. Likewise, the track two funding approach should be set up to provide support for the caregivers who want to provide team care, data linked care, and continuously improving care.

Medicare Advantage is listed as the first component of that two path strategy because Medicare Advantage is already set up to deliver care and Medicare Advantage already is a fixed payment model with a government defined and controllable cap on annual expenses. The government can easily cap care costs for Medicare Advantage every year by simply capping the amount paid to health plans for each senior who chooses to be a Medicare Advantage member.

Medicare Advantage currently caps the expense levels for the government for enrolled seniors very directly because Medicare now pays each of the Medicare Advantage participating health plans a flat payment every month per senior rather than continuing to buy care for those seniors by the piece. The Medicare Advantage plans already have the

flexibility to use that flat monthly payment from Medicare to buy care in different and creative ways from the existing care delivery infrastructure.

The program has its critics, but it has had notable successes.

The results to date have shown that the care delivery levels have been improved for seniors who have enrolled in Medicare Advantage plans.[249] Basic quality of care levels are measured for seniors who enroll in those plans. The quality levels are measurably better for Medicare Advantage patients in all areas where comparative measures exist.

The Medicare Advantage plans have received far greater levels of regulatory oversight than the traditional Medicare care infrastructure. The Medicare Advantage enrollees are currently protected by over 20,000 pages of regulations about various Medicare Advantage operational issues.[250]

Having people enroll in Medicare Advantage is track one of this proposed strategy -- and that track is explained in more detailed below.

Track Two Is Built on the Traditional Care Delivery Component

Track two for funding Medicare is to continue giving people who don't enroll in Medicare Advantage an enhanced extension of their traditional Medicare coverage. Track two continues using all American care providers who voluntary choose to be Medicare caregivers as the track two care network. That approach protects Medicare patient access for all caregivers who want to treat Medicare patients and who do not want to see those patients as part of one or more Medicare Advantage provider networks. Track two would allow Medicare beneficiaries who want to continue in the piecework care model to select their caregivers and their care sites from any and all caregivers who chose to be part of the traditional Medicare network of providers.

So what would cause the CBO to now give cost control credit of any kind for the expenses that would arise from the seniors who would elect to get their care from the track two traditional network of caregivers? We clearly have not been able to achieve targeted cost levels for the patients who get care from those caregivers in the past. Why would we be able to guarantee the cost for those care sites now? The answer is -- for track

two spending levels -- the government should set spending targets by geographic area and should annually make up for any expense overruns in each area by adjusting future fees for caregivers in that area to make up the difference.

To control future spending levels, Medicare would set a fixed per senior cost target for each geography. Medicare would guarantee that those spending targets would be met for the track one, Medicare Advantage patients by controlling the per senior payment level that is made to the Medicare Advantage plans. Medicare would guarantee that those same per capita expense goals would be met for all patients who chose the track two Medicare extension approach and track two care network by adjusting the fees and the payment levels downward in future years in areas when the cost targets are missed.

Medicare actually has had a somewhat problematic version of that retrospective fee adjustment approach in place in this country today. The current program is called Standardized Growth Rates or SGR. That program has not been a success. The current SGR program also calls for the fees that are paid by Medicare to be adjusted downward whenever Medicare misses annual cost increase targets. The current version of the SGR program has actually been a clear and absolute failure up to now for three main reasons. One reason for the failure of the SGR approach is that the payment reduction approach has not actually ever been activated as a fee reduction tool. Instead of adjusting future fees downward each year to make up for annual Medicare costs that have exceeded targets, the fee cuts that were needed to do that work have been ducked, deferred, and delayed every year…for both political and economic reasons.

Wishful Thinking Was Not a Good Cost Reduction Plan

The second reason the current SGR approach has failed is that it was far too broad in its scope and target setting. The current SGR approach was set up as a national goal with national penalties. That financial mechanism was far too crude and too macro to be an effective leverage tool or functional behavior motivator in any local care setting.

The current SGR did not and could not reflect any local cost realities or any local cost and expense level achievements. It was pure wishful thinking to believe that local caregivers across the country would change their behaviors or their care plans to somehow try to influence a national cost number. By contrast, the SGR-two model that is proposed by this book would be to set up and create very local cost targets and then do very local retrospective fee adjustments that are based on local performance levels. Local successes are possible.

The macro target that was set for the current SGR approach was so broad and so distant that it did not directly affect the behaviors of any actual caregivers. The likelihood of a local doctor becoming more efficient in some way with their Medicare patients in order to prevent a future national SGR fee adjustment from happening for the entire country is obviously pretty remote. It was really wishful thinking in one of its purest forms.

The current SGR approach has obviously failed entirely as a functional macro or micro motivator of either physician or hospital behavior.

By contrast, under the proposed SGR-two approach, the use of more local geographic area adjustments could actually be very motivating for local sets of caregivers. Using local fee adjustments could motivate good performance in collaborative ways on the part of local caregivers relative to both care costs and care volumes. The caregivers in a city could collectively decide that basic science based standards for CT scans should be jointly used, for example. That kind of collaborative care improvement work would make care better in local settings and it could help bring down local care costs. The likelihood of those goals having a local influence on collective behavior are obviously greater than the likelihood of a national SGR creating any collaborative local behavior or any changes in caregiver behaviors.

Magical Thinking Was the Third Reason for Failure

The third reason the current SGR-one approach has failed is that it had no strategy of any kind embedded in it. There was no related

strategy to reduce costs or to make care more effective or efficient in any way. SGR-one was purely magical thinking -- with no functional attempt by Medicare to help caregivers improve the costs or quality of care in any setting in any way. The SGR-one proposed impact on care delivery was a wish and a hope -- but it was clearly not a plan or a strategy.

By contrast, the newer SGR-two approach can benefit from some new tools that are being used to mitigate the costs of care.

SGR-two could build on all of the new tools that Medicare is making available for care improvement -- the new ACOs, the new medical homes, the new bundled payment approaches, and the new "meaningful use" rules for connecting electronic medical records between care sites. All of these approaches can help bring down the costs of care. ACOs are not magical thinking. Medical homes are not magical thinking. Local caregivers would be encouraged and incented to use all of those tools because successful use of those tools could help local caregivers achieve the annual cost constraint goals and avoid having future fees reduced by the SGR-two fee reduction formulae.

The cost calculation model for SGR-two could be relatively sophisticated in the application of the local goal to individual local care sites.

In cases where any of new ACOs are set up by the caregivers to accept the equivalent of a prepayment amount for their care, those sites could even be measured separately from the SGR adjustment used for the entire local geographic area. Those sites could be excluded from the regulation and fee-adjusted process if those sites that are ACOs and medical homes are achieving the targeted goals directly through their own performance levels.

That process would be a little more difficult to administer than a flat regional adjustment but it could be done because those sites already will be tracking relevant cost information as certified ACOs. The reason to use that approach is that using that kind of SGR-two approach could functionally guarantee scoreable savings for track two of Medicare for the federal government. Those saving will actually happen if the government has the will to actively implement the SGR fee rollbacks in those settings

where those rollbacks are earned by higher than targeted local Medicare costs.

If we set the cost target levels for both tracks at the right levels, the combination of the two tracks would give us the absolute ability we need to protect Medicare payments and expenses forward and to guarantee that overall cost targets will be met. If those cost targets are set low enough, they could end the need for the government to borrow money to fund Medicare deficits. Because the costs for both tracks are functionally capped, the borrowing could cease as soon as the program effective date for track one and track two happens.

Medicare Advantage Has a Great Set of Advantages

Medicare Advantage actually has the potential to stop the cost trend explosion for Medicare all by itself. Medicare Advantage plans are already strongly incented and empowered to use care enhancing tools like medical homes, subcontracting ACOs, expended quality reporting and continuous improvement approaches for various elements of care. Our country will not ever mandate full Medicare Advantage enrollment or order a full enrollment in Medicare Advantage to happen -- but if every single senior in this country was enrolled tomorrow in a Medicare Advantage plan, the defined contribution strategy of a fixed payment per month per senior that the government already uses to fund Medicare Advantage would give the government full and immediate control over all Medicare costs in one fell swoop. If every senior in America was a Medicare Advantage enrollee, the government could control per person costs for Medicare by simply controlling the per person payment that is made to Medicare Advantage plans and we would not need to borrow from our children to pay for Medicare expenses today.

Medicare Advantage Works Very Well Now

So what is the status of the Medicare Advantage program today? It is a popular program.

Roughly, 30 percent of Americans seniors have already voluntarily chosen to enroll in Medicare Advantage plans.[251] In the long established Medicare Advantage geographic markets, the percent of voluntarily enrolled seniors can range up to 70 percent.[252] For all of those seniors, Medicare has already stopped buying care by the piece. The government now buys the full package of care from Medicare Advantage health plans for a fixed price using the Medical Advantage payment approach. It is a relatively simple financial arrangement. The health plans who sell Medicare Advantage coverage must offer a defined package of benefits to seniors. Those plans are then paid a flat amount of money every month by Medicare rather than being paid fees on a piecework basis by Medicare.

When a senior enrolls in a Medicare Advantage plan, the government has no financial expense or exposure beyond the premiums that are paid by Medicare to the Medicare Advantage plans. Each Medicare Advantage plan takes all risk for care costs. The plan is responsible for the cost of care.

The plan also has to deal directly with all payment and financial issues related to problems like fraud and misbilling by providers of care.

The key difference between Medicare Advantage and traditional piecework Medicare payment approach is the cash flow.

Medicare Advantage gives the government a tool to buy full packages of care -- not just pieces of care -- from health plans and related care systems. The Medicare Advantage package price for each year is both fixed and guaranteed for both the government and the caregivers. Because the government pays a package price per member for Medicare Advantage enrollees, there is no chance that volume increases, fee increases, or perverse care decisions by any caregiver or any caregiver business entity will increase government costs. The MA program payment approach insulates the government from all of those cost drivers because the plans become the entities accountable for managing all of those issues and costs. That per capita cash flow model gives the plans great flexibility in dealing with caregiver business units. Medicare Advantage plans can be very creative in their contracting with their provider networks. Medicare Advantage plans can set up and fund medical home

relationships or can help care sites organize into accountable care organizations. In the process, Medicare advantage plans can set up cash flow arrangements with caregivers that are liberated from the traditional Medicare piecework fee schedule.

Medicare Advantage Insulates the Government From Provider Fraud

The Medicare Advantage payment model allows the plans to do creative and innovative things with caregivers in ways that can never be achieved under the standard, rigid, Medicare piecework payment model.

Interestingly -- and very few people recognize this fact to be true -- the Medicare Advantage program payment approach also insulates the government from provider level fraud.

Many people who look at health care policy issues literally do not know that particular benefit to be true. But that protection for the government cash flow against provider fraud is inherent to the Medicare Advantage fixed payment cash flow model. Fraud is a major and growing problem for the rest of traditional fee-paid Medicare today. One of the major operational priorities for the current piecework Medicare payment program is to reduce the hundreds of billions of dollars in provider business unit fraud that exist today. The government has been building extensive programs of auditing and payment review to help mitigate that fraud -- and yet the fraud levels for Medicare fee-for-service piecework payment programs continue to increase.

The fee-based payment business model that is used by traditional Medicare to buy care by the piece is obviously at the heart of the fraud problem. The temptations to commit fraud that are created by a piecework billing system that pays out billions of dollars by the piece are too great for too many healthcare business units to avoid. By contrast, the flat monthly payment that is made by government to Medicare Advantage plans insulates the government from that fraud. If fraud happens, the cost of the fraud is absorbed by the health plan and it is not passed on to the tax payer or to the federal debt through the Medicare fee-for-service cash flow. The plans, therefore, obviously each have a

very strong incentive to do their own fraud detection and prevention. It is often easier for the plans to do that fraud protection work, however, because almost all of the care providers for the Medicare Advantage plans are both in networks and under contract and that set of relationship helps mitigate fraud.

Medicare Advantage Has Robust Quality Reporting

Medicare Advantage also has a much more robust quality reporting mechanism compared to fee-based Medicare. Fee for service Medicare has a weak and woeful record of quality reporting and quality improvement. There are no quality reports, very little data, and very weak quality improvement agendas for traditional piecework Medicare. As this book had pointed out multiple times, quality screw-ups and care misfires increase the cash flow for many fee-paid Medicare provider sites.

By contrast, Medicare Advantage has a robust set of quality reports and quality improvement agendas. Solid quality reports exist today for Medicare Advantage patients for diabetic care, hypertension, heart disease and a whole array of other conditions -- with 55 separate measures of quality[253] and service now used to track care for Medicare Advantage members.

Paying attention to quality makes a difference. Overall, quality of care tends to be significantly and measurable better for Medicare Advantage patients compared to patients who get their care in the piecework Medicare payment approach. Some people had some initial concerns about quality for the first generation of the Medicare Advantage programs -- so extensive quality reporting has been embedded into the Medicare Advantage program in a way that has no parallel or equivalent function anywhere in the piecework Medicare payment model. Quality is reported, measured, tracked, guaranteed and transparent for Medicare Advantage patients and members.

The federal government has written thousands of pages of regulations about the operations of Medicare Advantage plans and Medicare Advantage members have clear mechanisms for reporting concerns about either quality, service or access to care.

Piecework Medicare Has Almost No Quality Reporting

That is very different from the quality agenda that this country uses for piecework Medicare. There are almost no quality measures now for the piecework payment approach that is used today by traditional Medicare. Basically, none. Medicare Advantage, by contrast, has grown to include nearly five dozen separate and relevant measures of quality and service. That entire quality agenda is a valuable asset that the government should utilize and build on as we look at how we can improve care and reduce costs for Medicare patients. It has taken decades to build up that robust quality reporting infrastructure for Medicare Advantage. The quality of care for Medicare Advantage enrollees is known, measured, reported, and comparative quality data is part of the decision-making process for consumers who are selecting their personal health plans.

The ACO Quality Measures Echo Medicare Advantage

The people who designed the new ACO quality measurement provisions for the new set of ACO regulations have built much of their quality reporting around that Medicare Advantage template and thought processes. When the ACO regulation designers looked for an approach to use to track and monitor quality, some of the existing Medicare Advantage quality reporting advantages were pretty clear. The standalone rules for ACOs ultimately settled for a “lighter version” of those MA quality requirements and changed some measurements because piecework paid providers often have a very hard time delivering good quality data.

The whole ACO effort is, however, as stated earlier -- very much directionally correct. But that whole ACO approach is just being constructed. Medicare Advantage, by contrast, doesn’t need to be built, constructed, invented or even reinvented at this point in time. The whole MA quality agenda isn’t theoretical or hypothetical. It’s very real. All of

the infrastructure needed to run Medicare Advantage is in place, tested operationally and fully functional.

There Is No Way of Knowing That Quality Standards Are Met for Piecework Medicare

As we take steps now to figure out how to figure out how to improve care and bring down the costs of care for Medicare recipients, we should be very aware that very few of the quality and service level oversight and data reporting approaches that are used for Medicare Advantage today exist in any way for the fee-for-service component of traditional Medicare. For most components of traditional piecework Medicare, the government literally has no idea if any care standards are being met. The new medical home and ACO reporting approaches will begin to provide some of the data, but at its core, the current piecework Medicare payment approach has no tracking mechanisms for the Medicare patients who have diabetes, hypertension, depression, or any other chronic conditions. Accountability levels for the care for piecework fee-based Medicare funded care approach have always been almost non-existent. It will not be easy to change in that piecework payment model. Creating any level of accountable care tracking for seniors who are not enrolled in Medicare Advantage plans will be extremely difficult. The new SGR-two proposal that is described in this chapter is intended to help improve that situation by steering as many fee-paid Medicare patients as possible into either certified patient-focused medical home settings or into federally certified ACOs -- places and settings where some new quality standards and reports are being built and implemented. Enrolling all seniors into either Medicare advantage plans or into SGR-two care sites with quality reporting will create better transparency for everyone about the quality of care, and it will trigger a more robust set of care delivery regulations.

The cash flow for the seniors who enroll in either track should be adjusted to reflect the health status of the seniors in each track. It is a good idea to adjust the payment level in actuarially legitimate ways to reflect the health care “risk” levels for each senior. Medicare Advantage

already uses that payment approach to reflect the differences in enrollment between health plans. The specific amount of money that is paid to health plans for each senior enrolled in a Medicare Advantage plan is basically based on the age and the gender of each senior. There is, however, also a significant adjustment made to the Medicare Advantage payment to reflect the health risk level of each member.

In other words, a Medicare Advantage plan is paid more money each month for a diabetic or hypertensive senior than that same plan is paid for a totally healthy senior. That risk adjustment payment model works for the government because it encourages health plans with good care quality and solid team care to enroll diabetic and other high risk seniors. That payment approach also doesn't encourage health plans to duck patients with chronic conditions and try to focus their sales efforts on enrolling healthy seniors. That health status adjusted business model works well for health plans because it encourages the plans to deliver great care for each diabetic member because the plans can keep their overall costs down by delivering better and more effective care to those patients.

Overall -- when care is delivered as a process and a package, care gets better. Diabetes is now -- in the standard piecework payment model -- the number one cause of amputations.[254] Diabetes is also the number one cause of kidney failure for Americans.[255] In the current fee-based payment approach, patients with diabetes consumes over 40 percent of all Medicare costs.[256] Forty percent is a lot of money. It's easy to see how that high level of expense happens for standard Medicare piecework patients. In the piecework approach, all care is incidental. Crisis care is rewarded rather than penalized in that payment model. Fees are piled on fees when crisis happen. Bad outcomes create even more fees in that payment model. Outcomes and care quality are highly problematic for far too many people under that piecework payment care approach.

The truth is that paying a package price for diabetic care makes a lot more sense than buying many separate pieces of care for diabetic patients. A package payment for diabetic care does not reward the failure of care. The business model and the care delivery model that results from

buying care by the package rather than just buying pieces of care has an economic elegance that works very directly in favor of optimal health and continuously improving care outcomes.

Medicare Advantage Sets Up Health Plan Competition Now

Quite a few health care economists have called for the creation of real competition in various elements of health care. The economists want competition so that the health care marketplace can achieve the benefits that typically result in other markets from real competition. Real competition in health care could involve buyers being able to choose between legitimate competitors based on value and price. Real competition clearly and obviously does not happen today in any real way in the piecework portion of the Medicare economy. Neither value or price competition happens for those providers of care.

Real competition does happen, however, between Medicare Advantage plans.

Medicare Advantage plans compete fiercely with each other today. The competition between the plans is set up in a context where seniors actually benefit from the competitive performance of the plans.

Medicare Advantage plans compete with each other in a safely regulated marketplace for senior enrollees. They compete today on the basis of functionality, service levels, benefits and prices. Those are excellent categories for competition. The per-senior monthly payment cash flow model works well to allow, enable, and incent real competition to happen between the health plans. The Medicare Advantage program currently engages market forces on behalf of seniors. That is a good thing. We really do need the energies that are created by competing businesses situations to be at play for our Medicare patients. Medicare Advantage uses health plans to be the competing entities. That competition happens in a clearly constructed and carefully managed market environment.

Seniors who are enrolling in Medicare Advantage plans already have a lot of information to use to make choices relative to both benefit sets and health plan care networks. Medicare has very effectively set up an

exchange -- that approach now for Medicare Advantage that allows seniors to choose between competing health plans based on service levels, quality and price.

This country is in the process of building new insurance exchanges in every state that will be used for the individual insurance portion of our non-governmental insurance market. One reason for us all to believe that new exchange model can work for that states and for that market is that a focused exchange approach works now for seniors and Medicare Advantage plans.

Medicare Advantage Cash Flow Encourages Plans and Providers To Work Together in ACO-Like Ways

One very important and extremely useful function of the current Medicare Advantage structure and cash flow is that it encourages health plans and caregivers to work together to serve seniors. Plans are learning to do that collective work with care sites and are doing it better every year. Plans can channel the Medicare Advantage cash flow into medical homes and ACOs with significant flexibility. Because the plans all sell entire packages of care to Medicare rather than just selling Medicare a list of fees, the participating health plans all have their own incentives, tools, strategies, opportunities and good reasons to work in increasing levels of partnership with an array of contracted providers to create team care and integrated care and variations on patient-focused care. That is happening today in multiple settings. Medicare Advantage plans are using a wide variety of creative care system linkages, allowances, and strategies to improve their Medicare Advantage product. Once again, a well-directed business model design is having a positive impact on both care and provider cash flow.

We May Need New Medicare Advantage Competitors

Some additional opportunities to extend competition even further for those patients could arise from inviting additional care organizations to become competing Medicare Advantage plans. The Medicare

Advantage set of competing plans could be expanded if some of the traditional care systems that are not currently health plans could be helped to function directly as Medicare Advantage plans. There are a number of hospital system and medical care sites that could effectively organize and build the additional capabilities needed to do that work and play that role.

There are already 563 competing Medicare Advantage plans.[257] That is more competition than exists in most areas of the economy. But in some markets, there are relatively few competitors. Allowing local care systems who have the right functionality to become direct MA plans might make real sense in some markets.

Health care organizations that already aspire to ACO status and who are building ACO capabilities and infrastructure might have a particular interest in evolving one additional step to be able to take on the direct Medicare Advantage plan role as well. Having additional competition in that market could be a good thing for some portions of the market.

A New Competitor or a New Monopoly or Oligopoly?

The impact of changing the competitive situation for caregivers is almost always very market specific. Organizing local care providers into a new freestanding Medicare Advantage plan could create a new competitor or it could create a new local monopoly or solidify a local oligopoly. Monopolies and oligopolies are not good. Thriving competition is good. So the issue of whether or not additional local caregiver organizations should become a Medicare Advantage plan is very site specific. There are more than 500 health plans that now compete for Medicare Advantage patients across the country today.[258] That number is sufficient to create significant competitions in most markets, but having additional competitors in a number of markets could be good for both seniors and the market.

So there are a number of reasons why getting people to enroll in Medicare Advantage plans makes sense for the government. Budget control tools would suddenly exist for the government for those seniors.

Expense caps become very real for that program. The government can very easily set a cash flow target for its own total expenses and they can achieve that target perfectly by simply setting up the annual Medicare Advantage payment level at a number that meets their cost target.

When you look at all of the relevant elements -- cost control, quality transparency, performance improvement incentives, fraud control, etc., -- it's obvious that the government would be more competent purchasers of care if Medicare recipients were enrolled in Medicare Advantage plan. It isn't a theoretical proposal or a hypothetical care model. The Medicare Advantage program plan is in place and it works.

How Can We Encourage Additional Medicare Advantage Enrollment?

So how could we get many more people to enroll in a Medicare advantage plan? We are not likely as a country to issue a mandate and simply require every Medicare member to join a Medicare Advantage plan. That would work logistically, but it would have political ramifications. The plans are popular and growing -- and a majority of seniors in each mature Medicare Advantage local market do tend to voluntarily enroll in the plans -- but the abilities of our government to require a mandated enrollment in that program for all seniors is problematic.

Longer Open Enrollment for Three-Star Plans

Since that is true, what approach could be done to get seniors to either migrate to Medicare Advantage plans or to cause Medicare recipients to get their care in a way that doesn't continue to cause Medicare costs to explode? There is actually a way to achieve that goal.

We Need Plans in All Markets

To go down that path, we would first need to be sure that Medicare Advantage plans exist in all markets. We also should to expand the

enrollment windows for Medicare Advantage plans for a couple of years to make enrollment easier for seniors. At the current time, only the Medicare Advantage plans with the very highest quality scores are allowed to enroll seniors 12 months of the year. Only 11 of the 563 Medicare Advantage plans have achieved that five-star quality rating,[259] so most seniors are now banned from enrollment in Medicare Advantage 10 months of the year. That enrollment opportunity in Medicare Advantage plans should be opened to 12 months for at least a couple of years for all plans who have three for more stars on the quality measurement level. It makes sense to make enrollment easier for a while for all plans that have earned three stars or higher. With the right enrollment programs, the number of seniors who voluntarily move to Medicare Advantage could grow significantly. Most seniors would probably voluntarily enroll over a couple of years if Medicare created the right marketing agenda for Medicare Advantage and then allowed the plans to run aggressive market based enrollment programs.

We Need To Also Control Costs for the People Who Don't Enroll in Medicare Advantage

As noted earlier, for the seniors who don't choose to join the Medicare Advantage program, we will need to offer the track two extension and continuum of the current set of providers that was described above.

The strategy for track two should be to help the caregivers who continue to work directly with Medicare with approaches that will improve their quality and their care. Obviously, having Medicare support patient-centered medical homes and ACOs should be a key element of that agenda.

We need the current infrastructure of care in this country to make active use of patient-centered medical homes, ACOs, and other forms of patient-focused, data-supported team care and we need Medicare cash flow to make that happen. This approach will only succeed if caregivers derive benefit from the new approach.

We need the existing infrastructure of care to benefit financially and operationally from using the new ACO and medical home tools for those patients. The SGR-two part of the track two strategy will be key to its successes. We can continue to pay for local care for local care from a wide range of caregivers on a piecework basis as long as we periodically adjust the fees if the total costs of care for any geographic area exceed the targets for that area.

If an area misses their cost target, we can simply adjust the fees in that area for each piece of care. As noted earlier, can move the fee levels in that area down as needed each year to allow each geographic area to achieve its own piecework model total payment cost target.

Other Countries Ration Cash, Not Care

We can and should implement all of the new care improvement tools in each setting to help make care better and more affordable. The real control and the absolute mechanism that CBO will recognize for limiting costs will, however, be the fee subsequent fee schedule adjustments. The truth is, we would not be the first country to control government program costs by controlling provider fees. Controlling fees is what most other governments in industrialized countries do now to control their costs of care.

Most other countries adjust the fees paid to providers each year to help achieve each country's annual health care cost goals. Those other countries who spend less than they do not ration care. They ration cash. They ration care costs by controlling care prices and fees…and not by rationing the actual delivery or volumes of care.

We could use a similar model here, for the Medicare recipients who are not enrolled in a track one Medicare Advantage plan. As noted earlier, local targets are far better than a national target. Using a macro one-size-fits-all national target doesn't make sense if we really want to encourage local care improvement. It really isn't fair to police and penalize providers in lower cost parts of the country for the higher costs that can be generated by the most abusive high cost parts of the country.

So the people who enroll in a Medicare Advantage plan will have costs approved for the government by the fixed payment per month -- and the people who stay with the fee-based care would have their costs capped by adjusting the fees.

Interestingly, having a two-path approach also could allow local providers who put in place successful ACOs to have their own cash flow reality. That new reality might lend itself to some very creative care delivery and care financing inventions and collaborations.

There could actually basically be three tracks of Medicare funding. Track one would be the Medicare Advantage track. Track two would be the traditional Medicare providers who decide to participate in ACOs or medical homes. Track three would be the stand-alone fee-for-service providers who deliver separate and unconnected piecework care with no alliances, no alignments, and no collaborations and whose fees would be annually adjusted if local spending levels exceed spending targets.

That multi-track approach could -- if done well -- achieve the same targeted macro cost per beneficiary down each Medicare funding track for this country.

Using a two track approach allows the Medicare program to continue to support both ACOs and medical homes, as well experimenting with various forms of bundled purchases of care. Every effort could and should be made by creative people in the care delivery infrastructure and in Washington, D.C., itself to make that portion of Medicare both successful and sustainable.

SGR Wasn't a Strategy -- It Was a Hope

It will seem strange to some people that this two track proposal involves a re-use of the SGR approach that had been both unsuccessful and remarkably unpopular.

The SGR idea had some merit. It was just badly done.

The old SGR approach failed, in large part, because no one did anything at any level to help it succeed. It was an orphaned program. The SGR strategy was connected to absolutely nothing real relative to any kind of cost constraints or cost mitigation of any kind. The idealists who

proposed the initial SGR hoped when they wrote that law that actual caregivers in this country would all know that the new SGR approach existed and that knowledge would somehow inspire many of the caregivers to do some kinds of good things that would keep care costs down -- doing those good things simply because the SGR program existed. That was well meaning as a theory, but, as noted, earlier, it really was magical thinking. Pure magical thinking. No one had any real assignments or real strategies or any real visions or plans to do any part of that cost constraint work. There were no tools of any kind for any Medicare providers to work with to achieve the SGR goals. The government set the SGR targets and then let them hover in the economy unconnected to any cost controls or cost mitigation functionality. That approach could not have been less connected to care decisions. No one was really changing care in any way to help meet that first set of SGR targets. That's why SGR-one failed. There was no accountability anywhere for anyone hitting SGR targets at any level in any place.

The first generation SGR approach wasn't a strategy. It was a hope -- a macro target based on wishful thinking and not on any kind of actual cost mitigation or care improvement agendas or strategies. It was both magical thinking and a blend of a voodoo economics with a touch of earnest idealism thrown in to make the approach feel good and politically correct at the time.

Today, we simply spend too much money on Medicare, and we are ducking the real issues and the costs we are creating are forcing our kids and our grandkids to pay for our care. This blended approach can allow us to stop using borrowed money to pay for today's cost of care for Medicare patients. The goal of the two-track approach should be to set up real spending targets that work financially to meet the budget goals of the government.

We Need Dependable, Long, Term Targets To Enable Reengineering

We will also want the new cash flow approach to set up real and dependable multi-year revenue targets that will give providers of care a

sense of stability about future revenue plans and cash flows. Stability should be a key priority for this entire strategy. Ask anyone who runs an actual care site why that is true. Stability of cash flow empowers and enables future actual reengineering of real processes at real care sites. We should set up the new Medicare cost targets for three to five years at a time -- we should not move the targets, payment levels or rate sets around annually. Assuring stability for future cash flows is actually very important in the real world for providers of care because it is a lot easier to do the really hard work that is involved in reengineering care in actual care sites if you know what the total cash flow will be for your care site when you are done doing the reengineering.

Very few people who have not been actually involved in the direct delivery of care understand how important it can be for care sites to have some stability for future cash flows to enable reengineering of care processes.

People underestimate the value of stability for triggering and funding the reengineering process for care. If the heart transplant programs mentioned in the last chapter had been encouraged to reengineer that care -- but if the buyers said that they might not actually pay the restructured package price for future heart transplants for more than one year, very little reengineering would have happened in those care sites. We need multi-year goals for Medicare costs. Knowing what future cash flows will be for Medicare patients will give providers a secure revenue stream to use as the core of the reengineering process.

Five Years Rolling Goals Could Achieve Multiple Results

The very best way of achieving overall success for Medicare and the infrastructure of care delivery in America would probably be to set specific total cost goals for the country for five years in advance and then to advance the five year goal annually and roll the full set of goals forward each year to create a new five year goal set.

Some people will object to having the macro cost cap numbers for Medicare presented as five year rolling goals instead of having annually

bid processes of some kind that could change prices annual or even sooner.

Remember -- the goal we want to achieve for Medicare stability and Medicare affordability is met if we achieve a defined multi-year Medicare spending level. Setting multi-year term goals that meet Medicare needs for a defined spending level is preferable to a process where financial goals for Medicare change annually -- and therefore the cash flow coming from Medicare could change annually.

Volatile Cash Flow Undermines Care Reengineering

That need for revenue stability for future cash flow might not make sense to some people who haven't tried to redesign the functional processes of care in the real world. People who don't know much about managing the actual functionally and operational structure of care delivery might advocate for a much more volatile cash flow model -- with prices and capitation levels for plans and caregivers varying year to year -- creating some real risk of year-by-year instability for the projected cash flow for care sites and health plans. Some people might suggest that the Medicare Advantage capitation levels should be set on an annual basis -- maybe even have the capitation levels set by some kind of annual market-based bidding process in each market.

One approach, for example, might be to have local bidding of some kind done each year with the annual bids from local vendors somehow creating the payment level for local Medicare Advantage plans for the next year or two.

There are a couple of problems with that short-term bid-based model. One problem is that the process steps that would be involved in using those bids to determine the actual annual cash flow for each plan is more complex than we need at this point to simply meet our goals. We should be entirely satisfied if a solid multi-year number built into the multi-year plan already achieves the Medicare's functional cost targets. Bidding processes can move costs up or bidding process could move costs down. Medicare doesn't need variable costs. Medicare needs guaranteed and affordable costs. "Good enough" should be "good

enough" for achieving the cost targets. For the next few years, to fully meet our immediate financial goals for Medicare we just need a multi-year guarantee that Medicare overall costs will go up no more than a target number for each year -- say, three percent.

We don't actually need the prices involved in Medicare funding to jump around. We just need the cost increases to meet our spending goal. And by declaring that fixed annual price increase to be the basis of the actual cash flow number, down each track, we will create whole new business model reality for the providers of care and for the health plans.

Cash Flow Stability Can Make Innovation Safe

Why is that true? This is an important reality to understand.

If providers and health plans both know three years in advance what Medicare advantage cash flow level they will have available as revenue each year, then every care site and health plan in America could start doing multi-year plans to work within that goal. Reengineering would be incented, triggered, and safely rewarded by that multi-year goal. Reengineering is the key. We very much want care sites to reengineer care costs for long-term success. If we change the cash flow package target for Medicare every year and if there is a significantly variability to the process that will creates significant future cash flow instability concerns for the people who run the business units of care -- both up and down -- then it will be much harder for most care sites and health plans to do both long-range planning and process reengineering.

Some people want to put the process up for bids of some kind every year.

Doing bids of some kind each year seems superficially like a good economic model -- and in some other markets, for some other products it often can be good economic model -- but health care needs a few years of cash flow stability to adjust to the new cash flow model. Using a bid process now to create variable cash flow levels each year isn't needed to achieve the cost goals for Medicare, and it adds both an uncertainty and a potentially unhealthy, perverse and counterproductive element of pricing gamesmanship to the planning process that could seriously

distract and derail the process-based thinking of health system leaders and discourage multiple levels of structured innovation.

Predatory Pricing Could Be Dysfunctional

A business model and an annual bid approach might allow some local organizations to do predatory pricing. Building new levels of annual competition based product gamesmanship around variable annual cash flow levels would also be less effective for creating massive process restructuring than setting up a more secure cash flow model with multi-year stability that lets people who run care sites do long-range planning in a very productive way.

That stability in the government stream of cash does not eliminate market forces from the model or the strategy.

Market forces will still be involved in this track one approach in a major way because the Medicare Advantage plans each have a direct price to consumers that faces consumers very directly. That price varies from plan to plan and plans compete now based on those prices. Plans all charge a premium to patients on top of their government capitation payment. The variable pricing part of the market agenda that triggers and rewards market forces should be the premiums that face the consumers and that are charged to the members. The variables pricing should not be the capitation levels paid by the government to the plans. Capitation based on variation would involve actuarial gameship. Consumers facing pricing trigger the benefits of consumer focused gameship. We want competition between the plans for consumers. Competition between plans for consumers at the premium level should be encouraged.

Likewise, for the rest of the Medicare members, variable pricing by the various Medicare supplemental plans should be encouraged. The Medicare supplemental plans under that approach can set their local prices knowing what the new SGR-two approach will do to basic costs in each geography.

We Could Also Raise the Eligibility Age or Means Test Medicare

This book recommends using the two track systems of Medicare advantage and SGR-two to get control over the costs of Medicare. A number of people have offered other approaches to solving the Medicare cost issues. A couple of those other proposed approaches to reducing Medicare spending levels deserve discussion and need to be understood.

Several possible solutions to Medicare costs have been proposed.

No one believes that the status quo approach is affordable for Medicare. Very bright people have been wrestling with those issues and some very good thinkers have been proposing a number of solution sets and strategies for making Medicare more affordable.

Covering fewer people would reduce costs.

One set of those proposed solutions to Medicare costs simply involves taking some type of steps to reduce the number of Medicare-eligible people. Clearly, Medicare costs would go down if fewer people had Medicare coverage. There are a couple of ways that have been proposed to reduce the number of people who have Medicare coverage. One way of reducing the number of Medicare enrollees would be to use some level of income or "means testing" to take Medicare benefits away from some higher income people. The argument for using that approach is that higher income people don't really need the Medicare benefit payments anyway. Removing higher income people from Medicare would, by definition, mean that fewer propel would have Medicare coverage.

The Medicare Edibility Age Could Be Involved

Changing the age of Medicare eligibility could also reduce the number of people with Medicare coverage.

Another approach to reduce the number of Medicare eligible people would simply be to increase the age of Medicare eligibility. Cover older people. Currently, everyone who reaches the age of 65 is eligible for Medicare. That age trigger could be raised to 66 or 67 or even 68 at some point in time. That eligibility age change would also obviously work

to bring down Medicare program costs simply because there would be fewer Medicare enrollees.

Each of those proposals can work mathematically to reduce the number of Medicare eligible people. Neither approach solves the basic cost trend problems for Medicare and neither approach does anything to improve the quality of care for Medicare patients. The truth is that forcing people to stay in the private insurance market longer when they are at age 66 and 67, will force those people who don't get Medicare coverage to buy expensive private health insurance. Insurance costs are very high for 66 and 67 year old people. Many of those people who would not be Medicare eligible would end up buying their insurance in the new insurance exchanges. Based on income, many of them would be eligible for the government subsidy. That new subsidy expense paid by government money would eliminate some of the savings for the government for those people. Adding older people to the risk pools would raise the average cost of care quite a bit for the other people who would also be buying their coverage from those same private insurance risk pools. The higher average cost of care for those pools that would result from adding people in their mid-sixties to the pool would make the pools and the premiums less attractive to younger people. The new actuarial realties that would result for those risk pools are easy to project and easy to predict. Adding people who are 66 and 67 years old to those private insurance risk pools would make coverage even less affordable for the people who are 40 or even 60 years old, and who have been paying their premiums based on the average cost of care in those risk pools.

Similar problems happen if Medicare eligibility becomes income-based. Having higher income people suddenly ineligible for Medicare would also force those higher income people into the new private insurance risk pools to buy their own insurance. The higher income people joining the private risk pools could be 70 or 80 or 90 years old. That migration to that buying private non-Medicare insurance by much older high income people could do even more damage to the existing risk pool expenses for the 40-year-old people. Premiums would again go up if those risk pools would need to accept significant numbers of 80-year-

old wealthy people who join and buy that private insurance because they were no longer eligible for Medicare coverage.

So both of those approaches could reduce the number of people with pure Medicare coverage -- and each approach would create unintentional consequences for other people who buy personal health insurance.

Flat Payments -- or Defined Contributions -- Are Also Being Proposed

This book is recommending the use of Medicare Advantage as a key part of the solution set for Medicare costs because Medicare Advantage has a cash flow that is based on a per enrollee per month guaranteed and fixed payment amount. Some policy advocates in Washington, D.C., have also been advocating recently for another kind of flat payment approach with a fixed payment per month that could also be used for Medicare patients. Those flat payment approaches have had multiple labels -- premium subsidies, premium support, Medicare vouchers, etc. Advocates for that flat payment/voucher approach basically recommend that we give all seniors a fixed amount of money to buy health insurance and then allow all seniors to use that fixed amount of money to buy a basic package of private health insurance from a private health plan. Seniors who wanted to buy more coverage could use their own money to buy the additional coverage.

That premium support approach could very clearly put a cap on government expenses for Medicare coverage per person because the total government expense for each senior would be the fixed subsidy payment -- not the cost of care for each senior. That approach looks very similar to Medicare Advantage in a sense that Medicare Advantage cash flow currently is also based on a form of flat payment from the government. The Medicare Advantage approach difference from the premium support proposals in that Medicare Advantage uses a more limited set of health insurance plans and Medicare Advantage has a more defined set of care benefits and performance standards and regulations. Some of the premium support plans that have been proposed have included a wider

and more open market approach that might allow any licensed insurance companies to sell coverage to Medicare beneficiaries. Some of the basic premium subsidy approaches that have been proposed would allow seniors to make a free choice of any and all licensed health insurers who want to sell insurance to seniors. The goal of that open market provision would be basically to encourage competition for seniors among a very wide range of health insurers and to encourage maximum flexibility relative to product design and benefit approaches.

Some of the economic goals that are embedded in proposals for that premium support/voucher approach would be very similar to the existing Medicare Advantage cash flow and cost constraints. The Medicare Advantage program pays plans a fixed amount per senior per month. Seniors can only choose between Medicare Advantage approved plans, however, to determine which plan gets their designated cash flow from Medicare. The premium support advocates generally recommend that each senior in the country be given a fixed amount of money that each senior can spend with any licensed insurer from any state to subsidize each senior's individual purchase of health insurance. Any licensed health insurer could be chosen as their insurance vendor by any consumer. Each senior could take their voucher amount and could use it to help purchase Medicare coverage from any of the competing plans in the private insurance market.

Both Approaches Create Plan Competition

One key goal of the premium support strategy is to have an increasing number of competing health plans in the market who will all offer Medicare coverage -- hopefully in creative and innovative ways. Ideally, seniors who had their premium support vouchers in hand could use their premium support money to purchase Medicare equivalent coverage in an active marketplace of many competing insurers.

The premium support advocates say that their approach would and could cap future Medicare cost increases. That could be accurate. That voucher cap approach -- if used for all seniors -- could and would create a major level of future cost control for the U.S. treasury.

The people who make that claim are correct. That flat payment aspect of their proposal and that cash flow model would, in fact, accomplish that cost control goal for the government as a payer. If every senior in America was on a "Premium Support" plan for Medicare on January 1 of next year, the total government expense for Medicare for next year would be the total amount of those fixed "premium support" payments -- and the cost increase for the following year for the government would be capped by whatever number the government chose as the next year's voucher level increase. It is a very basic and logical approach. That approach does not raise several concerns, however, in a couple a key areas.

Seniors Could Use the Vouchers to Help Buy Insurance

Proponents of that model believe that the new voucher marketplace should be geared to allow any willing health plan who can meet minimal license requirements to be eligible as voucher recipients.

That is a relatively low barrier to participation in the program. Some states have relatively low requirements for health plans to be licensed. Quality and operational oversight varies from state to state. Some health insurers fail financially. Not having higher standards for inclusion in the voucher edibility could create some problems for both stability and program quality.

Depending on the structure of the new market, some level of the competition between the new sets of voucher-eligible health plans would probably be based on product design. Insurers in a less regulated market context might offer an array of benefit approaches. That opportunity to design products could enhance creativity but it could create confusion and generate excessive complexity. Senior products can be very confusing now. Basing future competition on a wider range of benefit design options might not be optimal for the goal of achieving fully informed purchasing decisions by seniors. An open marketplace for the new premium support vouchers with multiple benefits designs offered by multiple plans could be incredibly complex -- with product choices made

available that are far beyond the capability of any senior to make an informed decision about relative to either quality or product elements.

That same open marketplace for any willing insurer could also lend itself to gamesmanship at several levels. Without some key structure and data flow set up relative to quality issues -- that approach could end up creating market forces and competitions between dueling actuaries rather than creating choices for consumers between competing care systems. The other chapters of this book would argue that having the competition for seniors taking place only at the level of the insurance structure and infrastructure rather than having competition based on care delivery performance would also probably be suboptimal. We really do need care systems to compete rather than having our actuaries compete -- because the cost of care is really what creates premiums in every setting -- not sophisticated actuarial tables.

Those issues could all be addressed. Several aspects of those premium support proposals could be improved. To make sure that seniors can make informed choices and to ensure that accountability exists for care plans, any voucher model that was set up probably could be made more robust by adding some practical and functional structure in the areas of benefit design clarity and quality reporting for care delivery. Since Medicare Advantage has clearly done a huge amount of that work, it might make sense to tie the premium support model market requirements and data flow in some way to that in place set of rules, processes and infrastructure. Using proven in place infrastructure to get a job done is often a good business decision as well as making pure administrative sense.

Patient Rollout and Rollout Delays Undermine the Savings Potential

Even if we deal effectively with those quality and complexity issues, there is still another major reason why that particular premium support approach and model might not meet our Medicare cost control needs today. The key proponents of those voucher-based plans have tended to become very cautious in their proposed time frames for plan rollout and

implementation. Most of the proponents of those premium support plans are now proposing a significantly delayed implementation time frame for Medicare. The advocates for the premium support approach are now recommending very slow and significantly extended implementation schedules for the premium support plan. That set of delays in achieving any cost benefits creates an obvious cost control problem. We need solid cost answers for Medicare quickly. The cost control needs for Medicare could operationally be met relatively quickly if all seniors on Medicare bought their care next year using those premium support vouchers, but that isn't the proposed schedule.

That is not the schedule and the scope of eligibility that the current versions of those proposals recommend. Next year is neither their recommended time frame or their proposed eligibility level. Key advocates of that approach have also pulled quite far back from the original goal of using the model for all seniors. The most recent versions being proposed for the premium support plans seems to have a significantly delayed implementation time frame, and they have clearly limited eligibility levels to exclude probably the majority of seniors for at least a decade or more. So it we are looking for short-term Medicare cost savings, the reality is that most seniors won't ever use the premium support approach as it is now being proposed and the program will start relatively slowly for the smaller number of seniors who actually will be affected.

Why has the proposal been limited in those ways?

Those changes are political -- not economic or operational.

To avoid having any direct impact on any current Medicare enrollees, the current premium support proposals all now have start dates that have been significantly delayed -- with current seniors staying on their current Medicare program indefinitely and only newly eligible seniors beginning to receive the premium support subsidies and vouchers at some future point in time as their personal cash flow model for Medicare coverage.

It's easy to understand why those delays in time frames and those reductions in the eligible seniors have been proposed.

The delays in the proposals have been done so that the political impact can keep all current seniors from being directly affected by the impact of the vouchers. The politics of that delayed time frame and limited enrollment makes complete political sense. The economic impact of those changes is, however, less positive. Those restrictions and those delays create a very expensive set of compromises and time changes relative to our goal of keeping us as a government from having to borrow money now to pay for current Medicare expenses.

In that time delayed implementation version, cash flow only evolves very slowly to a model where inter plan competition and care system competition can logically have any significant impact on the marketplace.

That is economically unfortunate.

Premium support proposals -- in their purest form and if they were implemented broadly and quickly -- could have exactly the massive impact on Medicare costs that their proponents advocate. Each delay in time frames and each reduction in the scope of the affected seniors obviously proportionately reduces that desired impact.

Medicare Advantage and a Two-Track Program Could Start Now

That brings us back to the first proposal in this chapter of this book. If we really want to stop having our kids and our grandkids pay with their taxes for today's Medicare expenses, then we should take a hard look at using the working tool kits we have in place right now to buy care for Medicare enrollees and we should use the best tools we have more broadly and more quickly. We could solve our primary cost problems for Medicare by simply broadening fairly quickly the use of the current Medicare Advantage program for the vast majority of seniors. We can also decide to have the seniors who do not choose to join Medicare Advantage receive their care from the independent care infrastructure and care sites that will be paid for Medicare patients based on the SGR-two approach. That blended model could achieve the cost targets we need to meet immediately and that combined approach could be done very quickly.

From a purely functional and logistical perspective, that two-track approach works with tools we already know how to use.

Medicare Advantage is here now. It could be used tomorrow to do this work. The challenge is to extend that program in a politically viable and acceptable way to more seniors. In many markets where Medicare Advantage has been available for multiple years, the majority of seniors have already voluntarily gone down that path and most eligible seniors in those existing markets have already joined Medicare advantage plans. Satisfaction levels for those enrollees are high and both satisfaction level and quality levels improve every year.

The Government Could Encourage Medicare Advantage Enrollment

If our government set a goal of having upwards of 80 percent of seniors in Medicare Advantage plans in five years, and if the government achieved that goal -- the government could then control Medicare costs for all those people based on the amount that would set each year as the per person Medicare Advantage payment level. That approach would achieve the full cost control levels of a full premium support voucher for 80 percent of seniors. For the other seniors, the SGR-two approach would encourage the use of team care, accountable care, medical homes and packages of care.

We Can Meet the Medicare Cost Goals With That Blended Approach

So that approach -- combining Medicare Advantage per capita payments with a modified regional SGR approach -- could meet our overall Medicare costs goals while improving care for both tracks of Medicare financing. That would be a wonderful achievement. Fixing Medicare would, of course, still leave a massive part of the federal health care budget unaddressed. We also need to fix Medicaid. We spend a huge amount of money on Medicaid and we will now be expanding that cash flow and cost burden for Medicaid hugely, as well. So how can we also take steps to bring the costs of Medicaid into line while improving service levels and the quality of care?

That work also needs to be done. That is the next chapter of this book.

We need to stop passing today's healthcare costs for both Medicare and Medicaid down to our children and our grandchildren through debt financing. It is a fiscal and even ethical sin for us to duck the key care delivery cost issues for political reasons and inflict that major burden on our kids and our grandkids when we have functional answers today that can eliminate that intergenerational cost burden and improve care at the same time.

Rationing care is absolutely the wrong answer. We need to reengineer, repackage, and reprice care. For Medicaid, we need to make care better and more accessible so that we can make it cost less. We need to reengineer that care in the context of a cash flow that enables, empowers and rewards reengineering. When that cash flow is put in place, and when it has enough longitudinal stability so that providers can count on it so they can reengineer care around it -- then we can alleviate the burden of those costs to state budgets and we can keep those budgets dollars free to spend the money on streets, roads and schools and appropriate local services.

It is time to improve our skill sets both as purchasers of care and as pure providers of care.

Both are entirely possible to do. We can do that work for our non-governmental markets by using the purchasing models outlined in the prior chapter. We need to buy care by the package, and not by the piece. We need care teams for our patients who consume over 75 percent of the costs of care[260] and really need team care.

We need electronic medical records for all patients and we need tools to connect the data for those patients. We need to make meaningful use of our patient data to improve care, support care, track care and study the results of care.

We should be on the cusp of a golden age for medical research using the new database. As an earlier chapter of this book pointed out, one recent study showed how to cut the death rate for stroke patients nearly in half with one change in procedure.[261] We need that research to

be done and we need tools to get the results of those kinds of research quickly to all relevant caregivers.

All of those goals are entirely achievable. We can use the new tool set for connectivity to provide remote monitoring, in home care, patient care plan coordination and continuously improving care processes. We just need a cash flow for care that encourages use of those tools instead of crippling the use of those tools. Vertically integrated care systems that sell packages of care have the business model needed to use and enhance those tools. So do well-designed Accountable Care Organizations, and well-designed medical homes, and appropriately paid health insurers and health plans who sell care by the package to employers and the government as Medicare Advantage or capitated Medicare programs.

We could be on the cusp of a golden age for care. We also need to be on the cusp of a golden age for health. That is the topic of the final chapter of this book -- improving our total health.

Medicare Advantage has continuously improving quality scores and very high patient satisfaction levels prove the approach model is viable and can get the job done of stabilizing costs and improving both service and quality. A plan to migrate seniors to Medicare Advantage plans -- coupled with a well-designed multi-year SGR-two cap for the annual payment increases for the providers and patients who are not enrolled in those plans -- can easily meet the CBO scoring standards for cost savings. That approach to Medicare funding could remove our dependence on borrowed money to buy Medicare claims in two years. Depending on where Congress sets the annual increase percentage, that blended approach could cut the Medicare cost increases to a fixed three percent each year and save the Medicare trust fund that is now scheduled to go broke in ten years from now. Saving the trust fund can be done. We should be deeply ashamed of ourselves if we don't choose to save the fund when we have the tool kit needed to save it and that tool kit will improve care in the process.