

**Remarks of Mark B. McClellan, MD, PhD to the
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Thank you for inviting me back, to be part of your annual, thoughtful discussion of the Trustees' Report. It's great to be back at AEI.

As in previous years, the Trustees' Report highlights one of the most important questions we face in public policy: How do we continue to improve the quality of health care for America's seniors and people with a disability, while making Medicare sustainable for future generations? You've just heard some important perspectives on this and related questions from some of the most thoughtful people I know.

I'm sure you know that while there are no easy answers, there is also no doubt that we need to take action now. As the Trustees note, "These projections demonstrate the need for timely and effective action to address Medicare's financial challenges."

Last year, I talked with you about three steps we were taking to provide a stronger foundation for sustainability in Medicare. I focused on a fundamental goal: Up-to-date care at the lowest possible cost is the key to the sustainability of Medicare, and the sustainability of our health care system. We can't afford any other kind of care, for the sake of our health and our wallets. This goal requires nothing short of a transformation in Medicare—costs are higher and outcomes are worse than they could be, because we were paying too much for the wrong kind of care.

To do this, I first talked about how we were shifting Medicare's focus toward prevention—putting just as much financial support into preventing diseases and managing conditions before they get worse as we have historically put into paying the bills when people get sick.

Second, we were supporting a robust Medicare Advantage program, to promote greater access to better coordinated care and benefits that keep up with our beneficiaries' needs and changing health care delivery.

And third, with our beneficiaries leading the way through their own choices, we were starting to pay for what really matters: better care at a lower cost, not just more and more services.

Today, I am going to update you on what we are doing. Medicare's transformation is well underway—from being an indemnity insurer that mainly pays the bills when people get sick, to a program that partners with our beneficiaries to drive improvements in the health of the nation and the costs of care.

I will also tell you that, challenging as these steps are, we need to do more to build on this foundation in the year ahead. So let me go through these issues in turn.

I want to start with our most important benefit for preventing disease complications—Medicare’s new drug coverage. We are delivering Part D coverage at a much lower cost and with better benefits than many independent experts had predicted.

In the 2006 Trustees Report, the costs for the prescription drug benefit for the next decade are 20 percent lower than projected just a year ago. This is the result of several important factors.

One is slower drug spending growth, as a result of trends like generic drugs becoming more widely available and widely used. Strong generic competition has been a priority for me since my time at the FDA, and I’m glad to see it paying off.

Another is greater-than-expected savings from negotiated reductions in drug payments, and other steps taken by the Part D drug plans to keep costs down. This is the result of aggressive competition, and the result of beneficiaries overwhelmingly choosing less costly plans.

Competition is working. People are getting better benefits at a lower cost—the direct result of giving them the opportunity to choose how they get their coverage, and the support they need to make their choice.

The vast majority of beneficiaries are choosing plans that cost less than the average. Ninety percent of beneficiaries have enrolled in plans other than the standard benefit designed by Congress. They are choosing plans with flat co-pays for different tiers of drugs, and plans that fill in the donut hole. With our help, and the help of thousands of partner organizations around the country, they are not only finding ways to get the benefits they prefer at a lower cost, they are also finding additional ways to save, such as shifting to less costly drugs.

A final reason that costs are not higher has to do with enrollment, which is strong but is occurring in a way that, while not unexpected, helps keep costs down. As of mid-April, enrollment in the drug benefit already exceeded 30 million. This includes people who have enrolled in a Medicare drug plan, and those who are continuing their non-Federal retiree coverage with a new subsidy from Medicare. It also includes about 3.5 million Federal retirees who qualify for the subsidy, but aren’t technically getting it because there’s not much point in the Federal government paying a subsidy to itself.

In addition, some people are continuing to get drug coverage outside of Part D. In particular, close to six million more beneficiaries have “creditable” coverage from another source—such as the VA, or their current jobs because they are still employed and employer coverage is primary.

We are now focusing our efforts on the remaining six million beneficiaries in the total Medicare population of 42 million. We want to make sure they get the help they need to make a decision about the new drug coverage.

More than half of these individuals qualify for the low-income subsidy, which pays 95 percent of their drug costs on average, unquestionably an extremely valuable benefit. But as previous efforts have shown, this is a historically difficult population to reach. By comparison, we are running ahead of historical enrollment of seniors in Medicaid in its early years—a large share of people who are eligible are still not enrolled—and in programs like Food stamps and SSI.

But we know we can do more. Medicare has launched some increasingly targeted efforts working to reach low income people in collaboration with the NAACP, the NCOA, and other groups. And when people qualify for the low-income subsidy, they will get a one-time special enrollment opportunity because of their change in status, even past May 15.

We are working very hard to reach the remaining several million beneficiaries between now and May 15. I can tell you that the upcoming deadline is helping many of them enroll. Maybe it's because signing up for health insurance isn't the most fun thing you'll do today, even though it is very important for your finances and your health, so the deadline helps people do something they had been meaning to do. Maybe it's because some people are healthy so they decided to wait.

But the deadline is definitely having an impact. Recently, I visited Texas for an enrollment event, and I heard about a woman who said that she only took a couple of prescription drugs and really didn't have any difficulties paying for them right now, but the deadline coming up reminded her that she might need more drugs when she got older. She was 102 years old.

Because of the grassroots outreach effort and the deadline, coupled with competition leading to much lower costs than expected, enrollment has already exceeded the point where many independent analysts, including health plan and Wall Street analysts, thought that it would end up for the year. This is good news for a sustainable benefit.

So enrollment is up, and costs are down. In addition to the larger than expected savings for beneficiaries, and 20 percent lower cost for taxpayers, states are also getting additional savings. State payments to Medicare—the so-called “clawback”—will also be 25 percent lower over the coming decade than projected last year.

The drug benefit is not the only important new preventive benefit in Medicare. We are now focusing on preventing disease rather than just paying for complications. We are providing much more support for screening and early diagnosis, with benefits that match up well, for the first time ever, with the recommendations of experts like the US Preventive Services Task Force. We are providing unprecedented access to care management services to help people with chronic diseases prevent complications. But even though we are now providing better benefits, many beneficiaries aren't yet taking full advantage of them, and so there are important gaps in prevention.

After May 15, we intend to use the same grassroots networks and personalized support systems for drug benefit enrollment to improve the effective use of the drug coverage, as well as the use of other preventive benefits in Medicare. The steps we've taken to bring the drug benefit on-line—community-based outreach, unprecedented partnerships, much greater support for beneficiaries and caregivers—have helped to make people with Medicare not just recipients of indemnity payments, but closer contacts in getting better results using our benefits. This kind of partnership will be a permanent part of the Medicare program from here on out.

Through this reorientation of Medicare benefits, we can reduce future health care spending on preventable disease complications. This redistribution of Medicare spending will not only lead to better health for Medicare beneficiaries, it will move us to provide the kind of prevention-oriented, personalized care that should be the hallmark of 21st Century medicine.

I've also described how Medicare Advantage plans are a key part of this transformational strategy. These private health plans compete by offering additional benefits and additional savings.

We are headed for full “risk adjustment” of our payments to the health plans. This means that new financial support for Medicare Advantage is going to plans that attract and retain beneficiaries who have chronic illnesses, where we have the best opportunities to reduce Medicare costs and improve health. It also means that competition is increasingly helping our beneficiaries with chronic diseases.

With risk-adjusted payments, we are seeing plans respond with better drug coverage, disease management, and coordination of services of special value to chronically ill beneficiaries. In fact, far from trying to avoid beneficiaries with chronic illnesses, a growing number of plans are specializing in providing more effective care at lower cost for the frail elderly, for beneficiaries with heart failure or diabetes, and for people with HIV/AIDS.

People in Medicare Advantage can now save over \$100 a month, on average, compared to traditional Medicare, with the largest savings for beneficiaries with chronic illnesses. That includes savings from additional drug coverage, and drug coverage with lower premiums. In fact, MA plans with zero drug premiums are widely available.

Since enrollment in the new benefits began on November 15, more than one million beneficiaries have joined Medicare Advantage plans, bringing total participation in the Medicare Advantage program to over 7 million. Most of the major Medicare drug plans also have a range of Medicare Advantage products, and Medicare beneficiaries in the stand-alone prescription drug plans are likely to become more familiar with these benefit choices in the months ahead.

And next year, in addition to the continued broad availability of a range of HMO, PPO, and private fee-for-service plans, for the first time ever we also expect to see Health Savings Account-type plans in Medicare.

In new programs like the new drug benefit, and the enhanced Medicare Advantage program, we are moving away from payment primarily based on the number and intensity of services. And that's the next major transformation I want to cover.

Until now, in most cases, Medicare has paid more when patients have infection after surgery or preventable readmissions to the hospital. We've paid more when patients have duplicative lab tests or imaging procedures, when good electronic records and decision support systems could have prevented these costs. We've paid more when patients have poorly-coordinated care, leading to more services, more errors, and more complications.

We've paid more when patients are in the dark about their treatment options, and have higher costs and worse outcomes as a result of being uninformed. But this is changing with the personalized quality and cost information in Part D, Medicare Advantage, and in the traditional Medicare program.

Better information on quality and cost, leading to real transparency in our health care system, is especially important for the success of consumer-driven health care. But it's important for helping any patient make informed decisions about their health and their health care spending—whether it's traditional Medicare, a private HMO, or an HSA plan—so that they can get better care at a lower cost. And it's also important to enable us to provide better support for health care professionals, who are trying under increasingly difficult circumstances to provide the best care for their patients. Too often, they're paid less when they take steps to improve care, as when they invest in electronic records or patient phone support systems that prevent office visits, complications and other more costly services.

To provide better support for high quality, less costly care, it's important to be able to identify it. That's why, at CMS, we are supporting privately-led, collaborative efforts to develop valid measures of quality and efficiency that can be used to make better decisions about care. These efforts, through collaborations like the Hospital Quality Alliance, the Ambulatory Care Quality Alliance, and the new Pharmacy Quality Alliance, are led by health professionals. But they include broad participation from other key health care stakeholders—such as employers, consumer groups, health plans, and others—to ensure that the measures will be useful and practical.

The Medicare Modernization Act and the recent Deficit Reduction Act have added to the momentum for greater transparency in quality and price. Next year, hospitals will have a two percentage point payment differential based on whether they report publicly on an increasingly broad range of quality measures—measures that are expanding to include not only clinical quality measures but also patient satisfaction measures, outcome measures like surgical complication rates, and survival rates for heart attacks and heart

failure. With that kind of payment incentive, we expect these measures to become very widely available.

We're also supporting development of a broader range of quality measures for physicians, nursing homes, and other settings of care. We're expanding information on the overall costs of care—costs of an elective surgical procedure or ongoing care for a chronic condition like diabetes, for example. Think about it—in advance, you could actually learn about the likely results of treatment by the different providers in your area, as well as the other treatment options available to you and their overall costs to you.

We are also going beyond making the quality and efficiency measures available. Through pilot programs, we are starting to pay more based not on more services, but on higher quality and lower overall costs of care. Indeed, in the Deficit Reduction Act, Congress asked for a plan for moving to value-based purchasing in Medicare by 2009, and we are on the path to do so.

There's good evidence that these value-based payment reforms can reduce costs and improve quality. For example, early evidence from our demonstration program with the Premier hospital chain shows that even limited additional payments can drive across-the-board improvements in quality, fewer complications, and reduced costs. We're also seeing the impact of enabling physician groups to keep some of the savings they achieve when beneficiaries get better care that prevents costly complications. We intend to expand these efforts to nursing homes, pharmacies, and other providers in the near future.

I want to emphasize that this doesn't mean Medicare will become the government arbiter of what exactly constitutes high-quality and high-value care. Quite the opposite.

One reason is, we're using quality and efficiency measures developed by privately-led efforts. In fact, Medicare Advantage plans in California and private plans and business purchasers elsewhere are leading the way in applying many of these measures.

Another reason is that valid measures of the overall cost and quality of care pave the way for true competitive bidding in Medicare. Instead of Medicare setting prices, Medicare can enable a range of providers to compete on quality and cost to provide a set of services for our patients. We're doing this with the plan competition in Medicare Advantage and Part D.

And we're starting to do it within the traditional Medicare program. For example, we've started a competitive bidding program for durable medical equipment in Medicare. We also are starting a new Competitive Acquisition Program for certain physician-administered drugs beginning on July 1, 2006.

Not too far down the road might be competitive bidding options for knee replacements, or diabetes care. Look for much more action from the agency, working with health professionals and other partners, to keep increasing the emphasis on supporting high

quality and low costs through competition based on better, personalized information in the months ahead.

Now, I've talked about the progress we've made to achieve better health care at lower cost—through quality, transparency, and better benefits like prevention and prescription drugs. While these are important steps, we also need to build on them through gradual, reasonable payment adjustments to slow the rate of spending growth.

As the Trustees note, measured and reasonable action now will forestall the otherwise inevitable need for drastic action later. According to the Trustees' Report, reducing the projected growth in per beneficiary health care costs by one percentage point would reduce the 75-year actuarial imbalance for the Hospital Insurance program by almost two-thirds. The steps I've just described can potentially help a lot, and the more quickly and effectively we pursue them, the less we need to depend on other steps to slow spending growth. But we can't wait—it's time to take some additional steps.

The President's budget has proposed incremental changes such as modest reductions in annual payment increases for some providers. These incremental reductions are based on the recommendations of MedPAC, the bipartisan expert advisory group for the Congress, and they reflect historical payment trends. The budget also makes it a high priority to ensure that Medicare can support those with the least means to pay for their own care, through a gradual increase in share of costs paid by highest income beneficiaries, while still providing highly subsidized insurance for all. These steps would significantly push back the insolvency date for the HI Trust Fund and the program's demand on general revenues.

The Medicare Modernization Act included an expedited process to consider legislation to reduce general revenue spending when it is projected to exceed 45 percent of Medicare spending two years in a row. We aren't waiting for that second year—we are taking steps now. We want to establish a process that can continue to make progress in the future.

The President's budget proposes a long-term framework keep up steady, gradual progress—in particular, an additional 0.4 percent reduction in spending each year when the 45 percent trigger is reached without effective action. To achieve continued progress in making Medicare sustainable, we're not wedded to any particular approach. As the budget points out, alternative proposals that achieve needed incremental savings would have an expedited Congressional review process. And the President has proposed a bipartisan entitlement reform commission to develop these further, longer-term proposals as quickly as possible.

The Medicare Trustees' Report offers a preview of Medicare's financial future if we don't take steps right now to improve the program's outlook. These steps begin with the

major changes we are implementing to transform how we pay and what we pay for, because high-quality care is the only kind of care we can afford.

Without continued progress to enable beneficiaries to choose the coverage they want at the lowest cost, without steps to pay more for better quality and greater efficiency rather than simply more services, we can look forward to more of the vicious circle we have seen again this year, particularly in Medicare Part B: a continuing increase in volume and intensity of services, because that's what we pay for now, leading to tighter and tighter controls on prices.

That's not the path to sustainability, especially when there is so much that health professionals and patients can do to provide better care at a lower overall cost...if our payment systems just give them the opportunity.

In the past year, with the implementation of the Medicare Modernization Act, we are putting Medicare behind a different future for our health care system. A future that supports innovative, prevention-oriented care because that's what people want, and we now we have the programs in place to enable them to get it.

By continuing these efforts, and reinforcing and expanding the most successful reforms, we can avoid drastic cuts and keep driving toward the best possible quality of care. We can support health professionals and patients in pursuing the best care at the lowest cost, we can alleviate the fiscal pressure facing the program, and we can reduce the need for other measures that seek to control costs without improving quality.

There *is* reason for optimism, because of the opportunities for Medicare to help us create a better and smarter health care system. If we do this right, Medicare will continue to protect and improve beneficiaries' health, and will be there for our children and grandchildren. And not only they, but everyone, will get better health care at a cost we all can afford.

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