

William D. Novelli
Chief Executive Officer, AARP
Getting Medicare Right
Center for American Progress
Washington, D.C.
July 11, 2007

Thank you, Cassandra. The Center is making very thoughtful contributions to health care policy.

One of the Center's concepts that I find very appealing is the idea of Wellness Trust to comprehensively improve health promotion and disease prevention in this country. I said as much recently in a speech at an American Marketing Association conference on marketing and public policy.

My remarks today are about getting Medicare right. But I want to point out that we at AARP see Medicare as part of a much bigger picture—the need for comprehensive health care reform in this country. This, along with long-term financial security, are among the very most important domestic issues of our time. We are devoting our efforts and resources to these transformational issues. For us, a key strategy is collaborating with other organizations, especially those with big ideas and innovative thinking, like the Center for American Progress.

With the demise of the immigration bill, it has become even easier to say that nothing important will be done legislatively in Washington over the next 18 months. And yes, gridlock has certainly been a defining feature of our politics and policies at the national level.

But as John Kenneth Galbraith, who coined the term, said, conventional wisdom, while usually conventional, isn't always wisdom. With Medicare high on the Congressional agenda, there is a substantial opportunity now to enact significant reforms in that program serving 43 million Americans.

AARP is working closely with congressional leaders as they develop their health care package. This reform package could achieve some very important goals: protecting Medicare beneficiaries from higher premiums; helping low-income beneficiaries pay for their prescription drugs and other out-of-pocket expenses; and providing health care to millions of uninsured children through SCHIP.

Medicare's Part B premium has doubled since 2000. The premium increases are due to continued rapid growth in the intensity and utilization of Part B services—including physician services and Medicare Advantage. We believe it is critical that the final package hold the line on premiums for Medicare beneficiaries.

Moving to level the playing field between traditional Medicare and Medicare Advantage must also be a key part of a final proposal. Current Medicare payment policy clearly favors the MA program over traditional Medicare, which is unfair to the majority of beneficiaries, who participate in the traditional program. We need to provide parity between the different parts of the program. And we need to put in place long-overdue health care principles that will serve Medicare beneficiaries and point the way toward higher quality and lower costs in our overall health care system.

Unless we act, overpayments to Medicare Advantage plans will total \$54 billion over the next five years, according to the CBO. We believe that Medicare payments should be neutral with respect to coverage options. Congress should set the benchmarks upon which MA plan payments are based so that MA payments do not exceed fee-for-service costs.

While the formulas behind these payment levels are complex, the effects of the overpayments are clear.

Overpayments to Medicare Advantage raise costs for beneficiaries in the traditional program. These payments are inequitable. They are also fiscally irresponsible, wasting Medicare dollars.

These overpayments negatively affect the solvency of the Medicare Trust Fund. CMS actuaries estimate that the date at which the Medicare Hospital Insurance Trust Fund would become insolvent would be pushed back by two years, just by equalizing payment rates between fee-for-service and Medicare Advantage plans.

We recognize the potential value of managed care plans, a value that cannot be fairly judged under the current distorted payment system. A number of our members are in these plans. The importance of care coordination and other principles of managed care plans should not be overlooked. In fact, those principles ought to be incorporated in the fee-for-service part of Medicare.

All health plans and providers need to demonstrate better performance and to be held accountable.

Medicare should pay for the quality of care, not the quantity of procedures. Medicare needs to elevate the value of care coordination, rely more heavily on electronic medical records, and reward physicians who provide effective, efficient and patient-focused care.

Medicare payments should be based on performance. We should initially reward physicians who make significant improvements in the quality of care they provide. Eventually, we should reward superior outcomes.

How do we move from concept to action on this complex topic that has so often been discussed? We believe that pay-for-reporting is a necessary first step. We ought to

condition fee increases on reporting data on specific quality measures. Pay-for-reporting sends a clear message that Medicare is moving toward a system that rewards quality instead of simply paying for procedures.

It seems obvious to say we ought to focus on the doctor-patient relationship, but the current payment system has a different standard. Physicians who conduct procedures are paid more than those who are diagnosing and managing complex problems. Physicians who take the time to talk to patients and family members about various options for treatment—the very thing patients most value—receive much lower rates of reimbursement. Either we need to reclassify physician-patient dialogue as a procedure—or we need a different approach.

Researchers at Dartmouth have found that communities placing a greater emphasis on primary care achieve lower cost and higher quality. A report by MedPac points to greater use of primary care and coordination of care as key strategies to improve efficiency.

For those individuals with multiple chronic conditions and particularly for those who move across care settings, coordination of care becomes even more important.

We need to change payment methods in Medicare to create incentives for care coordination in fee-for-service. A commitment to care coordination also should include greater use of nurse practitioners, physician assistants, and advanced practice nurses.

We believe the Medical Home model holds great promise for better care coordination for beneficiaries in traditional Medicare who have chronic conditions. It is now one of the demonstration projects under recently enacted Medicare legislation.

The patient-centered Medical Home model is designed to provide “targeted, accessible, continuous and coordinated, family-centered care to high-need populations.” Physicians would be paid for the time spent to coordinate care with family caregivers and other health professionals that is separate from—and in addition to—the work included in a face-to-face encounter. A key part of the Medical Home model is reliance upon health information technology.

We believe that another good idea is to offer bonus payments for demonstrated superior outcomes, on a risk adjusted basis. We ought to be paying for episodes of care, not procedures. If MA plans can achieve superior outcomes because of their ability to arrange coordinated care, we should pay for it, if the results can be demonstrated. For those in the traditional program, we should offer exactly the same financial incentive.

Focus on outcomes, not output. That is our guiding principle. And we’re not just advocating it—we’re acting on it.

In April, we announced our new health care provider agreements, which will take effect on January 1, 2008. These new contracts with United Healthcare for AARP members

65 and over and with Aetna for members 50-64 will tie payments to performance. They will sharpen the focus on health outcomes and access to care.

Partly because of their size but mostly because of the way they are structured, we expect these agreements to become a leading edge of health care reform.

At the heart of these contracts are economic incentives and penalties that relate to:

- An increase in coverage for the uninsured
- Increased access to health care and reduced disparities in care, particularly for diverse populations
- Care management, disease management, geriatric screenings and depression management programs, and
- Programs to monitor quality of care and patient satisfaction.

We'll assess the performance of the plans by measuring quality, efficiency and consumer experience. We'll publicly report results and use that transparency to help our members—and hopefully others—become value-based health care consumers. In that way, we'll help them develop healthier habits in their daily lives, prevent disease and make wise choices in their health care purchases.

We'll be moving forward with these agreements that emphasize health outcomes at the same time we're promoting Medicare reforms that go in the same direction.

The Medicare reforms that I mentioned will bring parity in how Medicare pays various plans; improve the performance of fee-for-service plans; and place a greater focus on outcomes. More importantly, they are a strategy to improve health outcomes in Medicare across the board.

Let me also point out that the agreement with United Healthcare will, among other things, make us the largest insurer of Medicare Advantage plans. This in no way changes our firm commitment—which I mentioned earlier—to level the playing field so that MA payments do not exceed fee-for-service costs.

AARP will also continue our efforts to control health care costs by making prescription drugs more affordable. We'll continue working to remove the prohibition on the Secretary of HHS from negotiating with pharmaceutical manufacturers and affirmatively require the Secretary to participate in such negotiations.

We'll keep working on behalf of the bipartisan effort in both houses to legalize safe importation of prescription drugs, starting with Canada. We're also urging Congress to let the FDA approve safe, cost-effective generic versions of biologic drug therapies.

And we're going to step up our efforts to provide additional funding for research of comparative effectiveness. Patients, pharmacists, doctors, and others need objective,

credible, evidence-based information on comparative clinical effectiveness to make the right choices.

This type of research can improve the quality of health care delivery and patient outcomes while reducing inappropriate, inefficient, and ineffective care. Unfortunately, Congress has authorized only \$15 million a year for this research, far below the \$50 million authorized in the Medicare Modernization Act. And we had to struggle to get the \$15 million.

Finally, to return to the health care package being considered in the House, a key element of that proposal is raising the asset test limit for the low-income subsidy under Medicare Part D.

As you know, we worked very hard to get prescription drugs into Medicare. One of the major reasons for our support is the additional help provided to low-income beneficiaries. Those who are eligible for the subsidy can get greatly reduced co-payments, low or no premiums, and no gap in coverage. Unfortunately, the strict asset test now in place means that millions of older Americans who need this extra help cannot get it.

Current law has the perverse effect of penalizing older Americans who, even with limited incomes, did the right thing by saving a small nest egg for retirement.

We believe there should be no asset test in Medicare. If there is such a test, the limit should be set substantially higher than it is now, and we are urging members of Congress to support the bipartisan efforts to raise that limit.

One more thing, as you know, part of the payment for Medicare and SCHIP improvements in the House bill would come from raising the federal tax on cigarettes. This doesn't just raise money, it drives down smoking rates, especially among kids. From our standpoint, this should be a no brainer.

We believe the reforms I have discussed today would make Medicare more equitable and more sensible. They are based on principles that would make Medicare work better for its beneficiaries and would improve health care delivery for others as well.

Just as gridlock can become a self-fulfilling prophecy, so can progress. This summer can be a season of needed changes and accelerated reforms in Medicare. I look forward to hearing your ideas and working with you to get Medicare right.

####