

**Speech by Mark B. McClellan, M.D., Ph.D.  
Administrator, Centers for Medicare & Medicaid  
Services  
American Enterprise Institute  
March 25, 2005  
8:45 AM – 9:30 AM**

Thank you, and thanks to everyone at AEI for inviting me today, and for your ongoing advice and counsel on so many public policy issues. I'm particularly glad to be part of the AEI tradition of hosting a serious, thoughtful discussion of the Trustees' Report. This is especially important now, when there are such major efforts directed toward making Social Security and Medicare sustainable.

After my talk, you're going to hear Medicare's independent actuary Rick Foster and some other Medicare experts go over the report's numbers and Medicare's financial status. I'd like to provide a context for those numbers: to connect them to what we're doing to improve the care Medicare beneficiaries receive now and to improve the sustainability of the program for the future.

So, what is the update on Medicare's financial future? Overall, the Medicare program's outlook has improved slightly from last year's report. We have slightly lower projected costs for Medicare Part A, which consists mainly of hospitals costs, and Part D, the drug benefit. At the same time, we're projecting higher Part B spending growth – more than 10 percent per year, reflecting the double-digit growth we've seen in Part B over the past year. We are looking into this closely, to understand exactly why Part B costs are going up so much when physician payment rates rose by just 1.5 percent and other legislative changes taking effect

reduced costs, such as more competitive drug payments overall in Part B. We are seeing a lot more billing for more extensive office visits, more lab tests, and more imaging procedures – and as I said, we’ll be saying more about this soon.

But the costs in the Medicare program today aren’t the main issue. Because of increased enrollment, rising prices, and especially greater utilization of new and more intensive medical services, Medicare costs are expected to double over the next decade.

According to the Trustees, the Medicare Part A Trust Fund will run out of money in 2020 – just 15 years from now. And while Part B and Part D have three-quarters of their financing from general tax revenues, which means that the funding for their trust funds rises right along with the actual costs of the benefits, there automatically is growing pressure on the federal budget. Altogether, between Parts A, B, and D, the middle-range estimate of the total 75-year unfunded liability for Medicare is about \$30 trillion.

This is an uncertain number, but it reflects some clear trends: increased enrollment, rising prices, and especially, greater utilization of new and more intensive medical services. To put the Medicare cost growth in perspective, according to the new Trustees Report, reducing the rate of spending growth for Part A services by one percentage point – one percent – would eliminate two-thirds of the 75-year actuarial deficit for the Trust Fund.

Now in many ways, this financing problem isn’t really news. Costs have been rising in our health care system for a long time.

But until recently, what aggravated the cost growth and made matters worse is that Medicare had out-of-date benefits. So we had a program that has been unsound financially, but also unsound for public health. The two go hand-in-hand. You need up-to-date benefits to avoid unnecessary medical costs. Otherwise, all you do is deal with health problems *after* they occur, which means more cost growth. It's *much* more costly in the long run – both in terms of dollars and in terms of our health. Again, these things go hand-in-hand. In the language of economics, we had a system that was highly inefficient. In everyday language, we haven't been getting as much as we should for our health care spending.

Now, I've been working on the problem of how we can get more for what we spend in health care, how we can do more to improve health at a lower cost, since I was a graduate student, and while I was working with AEI. But it doesn't take an AEI scholar to know that Medicare has been unsustainable, not only in terms of budgetary costs, but *also* in terms of quality and efficiency.

We need to solve both of these sustainability problems. They go together.

We don't solve them by leaving Medicare's benefits out of date. That just distorts the way health care should be delivered, away from modern preventive treatments, and it raises the cost of health care and sticks beneficiaries with these unnecessary costs.

And we don't solve them by imposing arbitrary government controls on prices and access to care, because those controls inevitably prevent people from getting the care they

need today, and they restrict the development of better treatments that should be coming soon.

Instead, for the sake of our beneficiaries and taxpayers, we need to reform this system that leads to paying a lot of money for inefficient, out of date, ineffective care. We must solve our sustainability problems with a focus on increasing quality and avoiding unnecessary costs – that is, a focus on performance.

And this year, we are taking major steps to make Medicare sustainable on both counts – financial sustainability, and sustainability in terms of quality and efficiency. The Medicare Modernization Act of 2003 gave us the opportunity to provide this foundation for sustainability. By turning Medicare into a program that fully supports efficient, high-quality, prevention-oriented care, we can provide the best foundation to keeping Medicare sustainable.

When people talk about the Medicare Modernization Act, the attention usually goes to the most obvious big change in Medicare – the drug benefit. That’s understandable, because drug benefit is a tremendous step toward getting Medicare’s benefits in line with modern medical care. After all, it makes no sense to pay for expensive surgery to repair an ulcer when you could more cheaply provide medicines that would prevent the ulcer in the first place. But prescription drug coverage is only one step.

The key strength of the MMA is that it builds that essential link between financial sustainability and high-quality care.

Our failure to deliver high-quality, effective patient care causes needless suffering and avoidable deaths, and much higher health care costs every day, all over the country. Too

many patients receive the wrong treatments or fail to receive the right ones even as our health care system leads the world in medical innovation. And that's not just new treatments, but well established ones as well. This has to end. In medicine, for the sake of our health and our wallets, high-quality care is the only kind we can afford.

So with that as background, I'd like to tell you about some of the things we're doing to meet this health care challenge. We are bringing Medicare into the 21<sup>st</sup> century. We're taking some new, aggressive action to get better care for our money – the hard-earned money of the American taxpayer. So I'd like to talk about ways we're using the MMA to make fundamental changes to the way Medicare works, and the way our health system will work.

**First, we're shifting Medicare's focus toward prevention. Instead of simply treating disease complications after they occur, Medicare will provide just as much support to proactively preventing diseases and managing conditions before they get worse.**

Increasingly, with better knowledge about the mechanisms of diseases and how they can be prevented in individual patients, modern medicine is becoming preventive medicine. Yet Medicare, designed before the era of preventive medicine, often doesn't help doctors and patients translate new knowledge into up-to-date, prevention-oriented care.

When I started this job, about 95 percent of Medicare spending went to treating health problems after they happen – paying for the emergency room, putting you in the hospital, or doing surgery when something goes wrong. Dealing with health problems after they happen means that hundreds of

thousands of Americans die prematurely each year as a result of diseases that may often be preventable, such as heart disease, cancer, and diabetes. That's not good medicine. That's not smart medicine. And that's not efficient medicine.

But that is now changing, fundamentally. This year, as Medicare benefits now include free cardiovascular screening to assess our beneficiaries' risk for heart disease and stroke, and free diabetes screening for those who may be at risk, Medicare's preventive benefits now match up well with the recommendations of expert groups like the US Preventive Services Task Force. And for new beneficiaries, we now cover a "*Welcome to Medicare*" physical. The initial Medicare exam is a particularly important opportunity for physicians to discuss the importance of preventive care and healthy lifestyle with Medicare patients and to start changing the way that our beneficiaries view Medicare.

Prevention doesn't end with timely diagnosis of disease. With most Medicare spending going toward the treatment of chronic illnesses and their too-frequent complications, some of the best opportunities for improving quality and reducing costs in Medicare involve better management of chronic illnesses. As my physician colleagues know, effective treatment of a chronic illness requires active involvement *by* the patient and support *for* the patient – not just providing diagnostic tests and treatments. Outcomes of care are much better and costs are much lower when patients understand their disease, including the medical and lifestyle steps they need to take to keep it from progressing. And as I'll talk about shortly, Medicare is no longer overlooking this basic medical fact.

Of course, the best-known feature of the Medicare law is drug coverage. Pharmaceuticals are an essential part of modern health care, particularly prevention-oriented care. So, instead of paying for surgery for bleeding ulcers or dialysis and limb amputations for diabetes complications, Medicare will pay for the prescription drugs that avoid these costly, intensive procedures. That's better for our health care system, better for patients, and better for taxpayers.

Now, Wednesday was a big day, and not just because of the release of the Trustees Report. It was also the deadline for applications for participating in the new Medicare drug benefit, and the new Medicare Advantage program. Based on the strong response to this program, which has been widely reported in the press, I can tell you that we will deliver the drug benefit on schedule, everywhere in the country, on January 1. Seniors will get the medicines they need, and because they can choose their drug coverage competitively, they will have coverage that automatically keeps up with modern medicine and that gets the best possible prices for their medicines. This includes not just "stand alone" prescription drug plans, but also enhanced drug coverage incorporated in Medicare Advantage plans, and a broad range of options for employers and unions and states to continue to provide and to augment drug coverage for our beneficiaries.

Medicare prescription drug plans will use many effective cost-containment mechanisms, such as formularies, drug utilization management tools, and pharmacy networks. They'll have to make good use of these tools to compete, to keep their costs down while offering attractive benefit packages for all types of beneficiaries. Health plans that can negotiate favorable retail drug price discounts and drug

manufacturer rebates and take other steps to manage utilization and costs effectively will be able to pass along the savings as lower premiums to beneficiaries. Prescription drug plans that are effective in these efforts gain a competitive advantage. Prescription drug plans that fail to do so will see their beneficiaries will switch to drug plans that offer better benefits at lower prices.

To illustrate how we are providing this coverage efficiently from the standpoint of our overall health care system, independent actuarial studies (including from the CMS actuaries and others) have concluded not only that our approach to getting drug prices down will lead to the lowest possible prices without compromising access to needed medicines. These studies also conclude that total spending on drugs on behalf of seniors won't change much, but utilization will go up substantially as average prices go down substantially. And utilization will shift toward drugs that offer higher value, including generic versions that are just as safe and effective as the brand names. That's much greater access to needed drugs, while preserving the strong rewards for developing innovative drugs, and all without substantially increasing total drug spending – a pretty good combination for avoiding unnecessary costs in our health care system.

So Medicare's benefits are finally in line with modern medicine. But having benefits isn't enough – we need to create a system that encourages, supports, and rewards the effective use of these benefits to provide coordinated, high-quality care. And that's what we're doing in our enhanced Medicare Advantage program.

Medicare Advantage plans are a core part of our drive toward more efficient, high-quality care. **That's why the**

**second fundamental change I want to discuss is our development of a strong Medicare Advantage program.**

Medicare Advantage health plans provide beneficiaries with additional benefits and coordinated care to help them prevent diseases and manage chronic conditions while keeping their costs down. These health plans now have strong financial incentives to help reduce costs and improve quality because beneficiaries can save a lot of money when they choose a plan that is more efficient. This is especially true for chronically ill beneficiaries as Medicare is moving rapidly to 100 percent risk adjustment of payments to MA plans. That means the new financial support for MA is going to improve care for patients with chronic illnesses so that plans must serve these beneficiaries well to be viable.

On average, MA plans save beneficiaries who don't have access to retiree benefits about \$100 a month in out-of-pocket costs – \$100 a month – because they provide additional coverage, benefits, and support beyond what is available in traditional Medicare. And beneficiaries in fair or poor health save much more. So as with Medicare's drug coverage, our reforms are getting more for our money in our health care system: we are giving seniors options that keep the total costs of our health care system down while providing better benefits and saving seniors a lot of money.

And I am pleased to say, we are already seeing the payoff from reforming the Medicare Advantage program to give seniors better, more reliable choices. This year, we have received over 125 new Medicare Advantage plan applications, including 50 plans completely new to the Medicare program and around 80 new PPOs. And we have more than 70 proposals for expanded service areas. We're headed for 47 states in the Medicare Advantage program in

2005. Based on these applications, we expect over 90% of all Medicare beneficiaries to have access to these lower-cost plans this year. And it's not just in the big cities anymore – three-fourths of rural beneficiaries have access to a Medicare Advantage plan, and one-third of rural beneficiaries have access to a coordinated care plan.

We're particularly pleased about the emphasis in these plans on improving care for chronically ill beneficiaries. Medicare Advantage plans can offer "Special Needs" plans to our frail and high-cost beneficiaries, including those who are institutionalized or dually eligible or who have other chronic illnesses. And already, more than 40 plans are offering special needs plans in 2005, and we expect an even larger number of special needs plans next year.

This year, we will have broader health plan participation than ever before in Medicare's history. And this includes a completely unprecedented level of PPO participation. It's a tremendous foundation for the additional health plans – including regional PPOs – that will be available in the 2006 program.

So putting it all together, this year is an absolutely critical time for bringing up-to-date benefits to our seniors and for taking our health care system into a new era. We're at a turning point, as Medicare puts the focus on prevention, with benefits that are up-to-date and stay up-to-date with the preventive trends in modern medicine. And we are getting there by giving seniors the option of modern health plans that succeed by lowering costs and improving quality, especially for chronically ill beneficiaries.

But important as a vibrant and reliable Medicare Advantage program is, that's not all we are doing to get the most for our

Medicare dollars and to move toward a more efficient health care system. We're also using the Medicare law to create a business case for high-quality, efficient care in our traditional Medicare program. Until now, Medicare has often paid more for more complications and for more treatments, regardless of their quality or their impact on patient health. And, of course, you get what you pay for. I know how frustrating this is for doctors and other health professionals who have lots of good ideas about how to use health IT or email or home visits for certain patients or other innovative approaches, yet Medicare will only pay for more visits, more procedures, more hospitalizations, and more tests.

Right now, for providers to see an increase in their payments, they must find a way to drive up volume and utilize more services. In turn, to save money, Medicare has two choices: cut payment rates or limit services. But none of this is directly related to getting the best care to our patients.

So we're making another fundamental change in Medicare to provide better support for doctors and patients trying to get the best results at the lowest cost. **We are starting to pay for performance, and that's the third fundamental change I want to discuss.**

I've already described how we're rewarding better quality and lower overall costs, especially for chronically ill beneficiaries, in our Medicare Advantage program. At the same time, we're piloting and implementing payment reforms to reward providers for better quality, better patient satisfaction, and lower overall health care costs in our fee-for-service Medicare program.

One example is our Medicare Health Support pilot program. Medicare Health Support is designed to help beneficiaries

with chronic diseases, such as congestive heart failure, complex diabetes, and chronic lung diseases, get the assistance they need to understand their diseases and to prevent complications. As I've said, these patients account for the majority of Medicare spending. And too often this spending occurs for services and complications we know how to prevent.

We're changing that. Organizations participating in the Medicare Health Support initiative get paid by Medicare when they get improvements in valid clinical outcome measures, patient and provider satisfaction measures, and total Medicare costs, *not* when they provide more services. Their payments come from some of the savings they create. That's the way Medicare should work: supporting and driving our health care system to get higher quality and lower costs. Medicare Health Support is one example of creating the business case for bringing high-quality care, prevention-oriented care to our chronically ill beneficiaries.

As another example, our Physician Group Practice demonstration announced last month is providing rewards to large, multi-specialty group practices for improving the quality and costs of care for their patients. Once again, the physician groups get higher payments when they get measurable improvements in quality of care and lower costs. Similarly, our upcoming Medicare Care Management Performance demonstration will reward small-to-medium physician offices for improvements in the care they provide to chronically ill patients.

And next week, as a result of a 0.4 percent payment incentive, we'll start reporting ten quality of care measures for almost 99 percent of the hospitals in this country – a

program that we intend to build on and extend to additional quality measures and other types of providers soon.

As we implement these pay for performance programs, we are seeing changes in medical practice. The participating organizations are investing in health IT systems that help doctors manage their chronically ill patients and make sure that all their patients get preventive tests. They are investing in telemedicine, and home visits, and personal health records to support beneficiaries. We are seeing assistance with understanding and using medicines appropriately for chronic diseases. We are seeing all of the kinds of things that doctors and other health care experts have been saying we need to make our health care system better and more efficient. And we're seeing them because we are starting to support them.

But we're not only giving providers better financial incentives to improve quality and patient outcomes, we're giving them much better support to take advantage of it through our state-based Quality Improvement Organizations, or QIOs. This includes special help for smaller providers, rural providers, and other providers who need help with reporting and improving performance.

We're now mobilizing for a new three-year work plan between CMS and the QIOs, and the plan -- or Scope of Work -- represents a new approach. The QIOs will assist providers who want help in taking advantage of our new pay for performance initiatives. QIOs will provide the measurement and data collection infrastructure needed to understand quality of care and how it can be improved, including advice and support with investments in health IT systems that have worked well for similar providers. And QIOs will promote public-private collaborations to help

hospitals, physicians' offices, nursing homes, and home health agencies succeed in improving performance. In conjunction with real rewards for quality improvement, this support will help providers achieve transformational improvements in healthcare quality by helping them work together and use proven approaches to make fundamental changes to process, systems, and organizational culture. As we work together to improve quality and efficiency in Medicare, QIOs are one of the ways that we will help providers succeed in quality improvement and pay for performance to raise the quality of care for Medicare beneficiaries.

There are many other steps we're taking under the Medicare law to support more effective and less costly care. We are implementing contractor reform aggressively. We are paying more accurately for drugs covered under Part B by using lower competitive prices rather than Medicare's higher regulated prices. And we also are getting ready to implement income-related premiums, so that high-income Medicare beneficiaries will begin to pay a larger portion of their Medicare costs.

The law also triggers fast consideration of further legislation, if within seven years, general revenue financing in Medicare is expected to exceed 45% of program funds. This could happen as soon as next year, and that's why it is so important to get this strong foundation for more innovative and efficient health care in place right now. We expect to learn a lot in the coming year about how much we can use preventive care, care coordination, drugs, and competition to put Medicare on a better financial track. An efficient, up-to-date Medicare program and health care system is the best

foundation for any further reforms to improve financial sustainability.

## **Conclusion**

Clearly, the Trustees' Report demonstrates that we must get more for our health care dollars. **The key to solvency is up-to-date care delivered at the lowest possible cost.**

And that's why it's important to remember that the MMA is about far more than just prescription drugs. We are working so hard this year because we have a historic opportunity to save Medicare by bringing it up to date. We know that if we make the most of our historic opportunity, ***our unique opportunity***, we will not only succeed in giving our beneficiaries and taxpayers better care for the money. In addition, because Medicare is so big and because we are partnering with health professionals and other health care payers in many of these quality improvement efforts, we can make our whole health care system work better.

Thank you.

###