**KHN's 'What the Health?'**

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**Julie Rovner**: Hello and welcome back to KHN's "What the Health?" I'm your host, Julie Rovner, chief Washington correspondent for Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're here to bring you the latest news about health policy from the White House, Capitol Hill, federal agencies, and the states. We're taping this special Medicare deep dive on Wednesday, Aug. 14, [2019], at 2:30 in the afternoon. As always, news happens fast, and things might have changed by the time you hear this. So here we go.

**Rovner:** Today, we are joined by Paige Winfield Cunningham with The Washington Post.

**Paige Winfield Cunningham:** Hello, Julie.

**Rovner:** Joanne Kenen of Politico.

**Joanne Kenen:** Good to be here.

**Rovner:** And Kimberly Leonard of The Washington Examiner.

**Kimberly Leonard:** Hi.

**Rovner:** And a reminder about the schedule: We're taking next week off, so we'll be back in your feed on Thursday, Sept. 5. So we're changing things up a little bit this week. As you may or may not know, Kaiser Health News is an editorially independent program of the Kaiser Family Foundation (not affiliated with Kaiser Permanente). KFF is full of some of the very smartest people in health policy, and I thought we should start taking advantage of that expertise in the run-up to the 2020 election. So we're going to start today with a closer look at the Medicare program, not "Medicare for All," but the actual Medicare program created in 1965. In the coming months, we'll do explainers on Medicaid and the other big parts of the U.S. health care system. We'll have our regular panel discussion. But, first, I'm going to play the interview I did with Tricia Neuman, KFF's Medicare expert. So here's the interview, and we'll see you on the other side.

**Rovner:** We are pleased to welcome to the podcast today, Tricia Neuman, who is my colleague at the Kaiser Family Foundation and the senior vice president in charge of the foundation's work on Medicare policy. Tricia, thank you for coming down to the studio.

**Tricia Neuman:** Hi, Julie. Thank you for having me.

**Rovner:** So, let's start with the very basics. What is Medicare, and who gets it?

**Neuman:** Medicare is a national health insurance program, but people think of it as a program for just seniors. But it's a program for 60 million people, including about 10 million people who are

under age 65 with permanent disabilities. So it's mostly for seniors, but there are younger people, too.

**Rovner:** To add a layer of confusion, some disabled people end up on Medicare and some end up on Medicaid, right?

**Neuman:** Right, exactly. Just to jump right into confusion … To get on Medicare with a disability, you have to qualify for Social Security disability insurance. And just [to] get right into technical stuff, people with end-stage renal disease can get on Medicare and people who have ALS, which is known as Lou Gehrig's disease.

**Rovner:** So there are a number of ways to get on Medicare other than turning 65.

**Neuman:** But the main way — I mean, the fair way to think about it — it's mostly a program for people 65 and older.

**Rovner:** And is it automatic when you turn 65?

**Neuman:** Well, it used to be more automatic than it is today, which is why people used to love it, because it used to be tied to Social Security. But now, as people are delaying Social Security because they want to get the full retirement benefit, then it's not so automatic. So people when they turn 65 need to make a decision about whether they do want to sign up for Part B or not. Part A is automatic, and maybe we'll get into those A's, B's, and C's because that's confusing.

**Rovner:** That's my next question. I would say Medicare isn't really a single program at all. It's more like four or five. How would you break down the component pieces that together make up Medicare?

**Neuman:** Right. So there are these A's, B's, C's and D's and some people can even think of more. So, Part A is the hospital insurance part of the program that mainly covers inpatient services. People might see that they pay their payroll taxes when they look at their salary statements. That's what's going into the Part A hospital insurance trust fund, and that's the services that they pay for.

**Rovner:** And those are the people who say, "Well, I paid for Medicare …"

**Neuman:** "I'm paying for my Medicare." And you are paying for your Medicare. It's going for Part A. Then there's the Part B part of the program — that's physician and other outpatient services. That part of the program is paid for a little bit differently than Part A because it's paid for by premiums and general revenues. Then there's Part C. People don't really call it Part C, but it's Medicare Advantage.

**Rovner:** They used to call it Part C.

**Neuman:** They used to call it Part C, but, really, people are now calling it Medicare Advantage. That's the part of the program that pays private insurers a capitated amount, a fixed amount — and these are HMOs and PPOs, largely. Then there's Part D, which we used to call the new Medicare drug benefit. But now it's been around for, since 2006, and this is unlike the other

benefits covered by Medicare because it's provided exclusively by private plans. And I said there's more than the A's, B's, C's and D's — and in some ways joking — but a lot of people in Medicare have supplemental insurance, and those plans can have letters, too. So that's why people sometimes think, "Wait, I have G and I have C and I have B and whatever." Medicare itself has A, B, C, and D.

**Rovner:** OK, so we hear a lot about Medicare Advantage. Let's talk about that for a minute. Who has Medicare Advantage and why would you want Medicare Advantage rather than traditional Medicare?

**Neuman:** Right. A growing number of people are choosing Medicare Advantage plans. Again, these are HMOs and PPOs — offered by private insurance companies. We hear a lot about why people are choosing it right now. A third of all people on Medicare are choosing, are enrolled in a Medicare Advantage plan. So that's a sizable share of the program. And when people are talking about Medicare for All and wanting a Medicare-like program, I'm not sure they're really thinking about how Medicare has evolved into a system that looks more like a marketplace in many areas, because there are all these private insurers who are competing for business and have a lot of Medicare enrollees. Why do people want to sign up? For different reasons. Some people like the simplicity of it because they have to have Parts A and B, but they don't have to buy a separate Medigap policy and they don't have to buy a separate Part D plan. Some people like it because they've been with that same insurer during their working years, and it's familiar to them. So they turn 65 and they say, "I want to stay with that company." And some people like it because they see the ads on TV and they like the idea of a gym membership or some dental benefits. That's very attractive. And finally, the premiums and the cost sharing can be lower, particularly for healthier people if they're in a Medicare Advantage plans. So there are a number of advantages to Medicare Advantage plans. Of course, there are always some downsides because there are trade-offs in any option.

**Rovner:** And, obviously, the downside of Medicare Advantage: One is that unlike traditional Medicare, you have to stay within the network. But there are other potential downsides, too, right? Like if you want to switch.

**Neuman:** Right. If you want to switch, for one, you have to wait till the end of the year and switch during the open enrollment period. Another issue we have encountered is that people who might want to go back to traditional Medicare and buy a Medigap policy can't really do that because Medigap in many areas is not available to people with preexisting conditions if they've been on Medicare for a while. So that's something people don't really think about. But it's an important consideration, especially because Medicare doesn't have an out-of-pocket limit — [meaning] traditional Medicare. And so people like the idea of a supplement because it provides them financial security.

**Rovner:** Let's talk about for a minute what Medigap is, and then we can talk about Medicare's cost sharing and why people might want it.

**Neuman:** Right, exactly. So Medigap is a supplement to the traditional Medicare program. Most people who are in traditional Medicare have some kind of supplement. Believe it or not, many

people still have an employer wraparound plan. The lower-income people have Medicaid, which helps with premiums and cost sharing and, for many people, extra benefits. But for middle-income people who just want to give themselves added protection, they can buy a Medicare supplement. They've been around for years and they're very popular. More than 10 million people today have a supplement like that.

**Rovner:** And you would need a supplement because Medicare, even though people like it, has a lot of cost sharing, doesn't it? It's not … it is not cheap. Unlike the Medicare for All plans that we keep hearing about, that would cover everything with no premiums or deductibles or copays — that's not what the current Medicare program looks like.

**Neuman:** No, it’s definitely not. So Medicare has actually three deductibles because of the different parts: the hospital Part A that we talked about, there's a hospital deductible, which is more than $1,300 per benefit period. The Part B part of the program, for physician services, also has a deductible, now $185. And the Part D plans, they may or may not have a deductible, but the standard deductible is $415. If you put all of that together, you're close to $2,000 in deductibles. So that's not nothing. Plus, there's cost sharing for the various services under Part A and Part B and Part D. So people in traditional Medicare can have significant out-of-pocket expenses for covered services. And that's not even talking about the costs they incur for services that are not covered that really matter to this population, like dental, vision and, most especially, long-term services and supports at home or in a nursing home, which can wipe out the average savings of many, many people in the program.

**Rovner:** And to be clear, Medicare has a nursing home benefit, but it's limited.

**Neuman:** Very limited, no more than 100 days and it’s skilled nursing.

**Rovner:** So basically, if you're coming out of the hospital and you need rehab and you can be returned to …

**Neuman:** … the community home, then you can go into what's called a skilled nursing facility or you can get some home health and other therapy. But if you have dementia and you just need someone to help you at home, no, Medicare's not going to cover that on a long-term basis.

**Rovner:** And it never has.

**Neuman:** And it never has, and it's an ongoing issue that just has yet to be addressed.

**Rovner:** So one reason that politicians use the phrase "Medicare for all," when they are actually talking about a program that would be very different from Medicare, is that Medicare is popular. It's really popular. How popular is it? And is it surprising that it's so popular considering that it's not actually all that generous?

**Neuman:** Well, it's a kind of off-the-charts popular. I mean, more than 80% of people say this is a great program. And that's true for Democrats. It's true for Republicans. It's true for Independents. And it's true year after year after year. When you ask the general public, Medicare gets high ratings. And when you ask people who are on the program, Medicare gets high ratings. Why is it true? That's a great question. I mean, it might be the fact that you get your coverage without

regard to medical conditions. So there's no preexisting condition worries. You get Medicare without regard to income, so you don't have to meet any kind of income test or go down and apply to any office to get benefits.

**Rovner:** Although you do have to pay more if you are wealthier, which we didn’t mention.

**Neuman:** Yes, you do. And probably this is a huge issue: With traditional Medicare, at least, doesn't have the roster of doctors and hospitals that you mentioned for Medicare Advantage plans. People in Medicare can see virtually any doctor and go to virtually every hospital in the country.

**Rovner:** And while there are some doctors who don't take Medicare, there's almost no hospitals who don't take it.

**Neuman:** There are almost no hospitals. And truthfully, most doctors do take Medicare if they have an open practice. So they may not be taking any new patients but, if they are, they're generally taking Medicare patients, although there are parts of the country where this could be an issue.

**Rovner:** So the other thing that we hear, in addition to Medicare for All, is about a Medicare buy-in program. Now that actually might put more people in real Medicare, right?

**Neuman:** Yes and no. It could. It sounds like it could. But sometimes when people are talking about a Medicare buy-in, they're talking about a program that looks like Medicare, but isn't exactly Medicare. And sometimes when people are talking about a Medicare buy-in, they're talking about a buy in for older adults, 50 to 64. That does look a lot like Medicare. But often these proposals wall off the Medicare program because there's this concern that a new population could drain the resources that are needed to pay for the current Medicare population, and an aging population. So it looks like Medicare. It has a lot of Medicare features, but a buy-in may or may not be the real Medicare program as we know and love it today.

**Rovner:** Well, I'm glad you brought that up because we also hear, when we talk about Medicare, that it's going broke. Is Medicare going broke? Can Medicare even go broke?

**Neuman:** No, Julie, it just can't go broke. I'm not saying there are no financial challenges facing Medicare. We do have an aging population and boomers are coming on. Medicare spending itself has been growing relatively slowly per person, which people tend to forget, and there hasn't been a lot of conversation about how to finance care for an aging population. But this program can't go broke per se. There's a part of the program, the Hospital Insurance Trust Fund, that will not have enough money coming in from everybody's payroll taxes to pay all the benefits required. Right now, the projection is 2026. The projections tend to fluctuate, but it is not going to go bankrupt per se. It's projected to not have quite enough money to pay its obligations. And while that could be worrisome, in the past, Congress has stepped up and made changes in order to keep the program afloat.

**Rovner:** When I started covering Medicare — back when I was barely old enough to vote — Medicare policy was by far the primary way that Congress made health policy, in general. Talk for

a little bit about how influential Medicare policy has been on the rest of the health care industry. It used to be that whatever happened to Medicare happened to everything else, eventually.

**Neuman:** Well, Medicare still is hugely influential. When Medicare adopts a payment system, it's often replicated in some form by private insurers. Medicare is just a really big deal. It's 20 cents of every dollar spent in health care in our country, and it's 30 cents on every dollar spent on prescription drugs, which is a big deal. And it's 25% of hospital spending. So, when you touch Medicare, your finger's on Medicare but it's really on the entire health care system. So I don't think Medicare is going to fall very far off the agenda. And we're hearing about Medicare actually come back on the agenda in the context of these Medicare for All discussions. But I suspect we're going to be hearing a lot more about Medicare when Congress at some point comes back to what's going on with the deficit, what's going on with the debt. Because when those conversations come to the surface, Medicare is always front and center because Medicare is also a fairly large share of the federal budget.

**Rovner:** And I forgot, because some people don't know this, that Medicare actually pays for the education of most of the nation's doctors.

**Neuman:** Graduate medical education. Absolutely. And so I think people understand some of the roles that Medicare plays, but not all. And that's obviously a hugely important one that people talk about reforming that system, but that hasn't quite happened yet.

**Rovner:** I'm always amazed that people are surprised because I forget it's not [an] obvious thing that Medicare actually funds most of the graduate medical education in the United States, since these are the interns and residents, not the medical school part.

**Neuman:** Exactly.

**Rovner:** That's always been a big piece of Medicare.

**Neuman:** And Medicare has also helped to support rural hospitals, teaching hospitals. So there's the explicit role of Medicare in helping to pay for health services for people who are covered by the program. But there's also the broader public mission of the program that gets less attention.

**Rovner:** Speaking of Medicare's influence on the rest of the health industry, one of the major flashpoints in the drug price debate right now involves the question of whether Medicare should or should not have the ability to directly negotiate drug prices. Can you explain what that argument is about?

**Neuman:** Yes. This this has to do with a small phrase that was put into law when the Medicare drug benefit was enacted in 2003.

**Rovner:** With a Republican Congress and president.

**Neuman:** With a Republican Congress and president. And people across both sides of the aisle voted for this law. But toward the end, a little phrase was snuck into the bill that prohibited the secretary — meaning the secretary of the Department of Health and Human Services — from interfering in the negotiations with respect to drug prices. So this so-called "noninterference

clause" has tied the hands of government officials, so they really can't get involved in anything related to prices. Now, in some ways, the benefit has been set up so that there are these other entities that are negotiating drug prices. But still people find it pretty extraordinary that the secretary has a gag order. In essence, the secretary can't step in to negotiate even for high-cost specialty drugs when there are no competitors. So that's really the debate, and this is a debate I think we'll be hearing about in September [or] whenever it is the House takes up the issue of giving the secretary authority to negotiate prescription drugs. It was not in the Senate Finance package, but there's so much public support for this. Really on both sides of the aisle, there's a lot of interest. People just think: "Why not? Why tie the hands of the secretary for such expensive drugs?"

**Rovner:** Would it work, though? Because, I mean, the Congressional Budget Office has said any number of times that the only way negotiating works is if the federal government would be able to say "no" and walk away from the table. "If you don't give us a better price, we're not going to offer your drugs." And then people won't be able to get their drugs at any price

**Neuman:** Exactly.

**Rovner:** You'd have to basically make a formulary, make a list, in order to make this work, right?

**Neuman:** The Congressional Budget Office has been pretty consistent that if you just strike the language, you're not going to get savings. It's unlikely to do something because there needs to be political pressure on the secretary to do something real and there needs to be pressure on the drug companies to come to the bargaining table. I don't know that there necessarily has to be a formulary, which would be a bit odd in the case of Medicare, because right now all the plans are establishing their formularies. But I do think that there would be a way of establishing criteria for the types of drugs that would be subject to negotiation and the constraints on prices.

**Rovner:** As you mentioned, the ones that there's no competitors for …

**Neuman:** No competitors. One could think of different ways of putting together a list. But if there's sufficient pressure or definition given to the secretary and strong enough motivation for drug companies to come to the negotiation table or else risk something that is meaningful to them, I think it would be possible to get savings. And so I think that will definitely be high on the agenda when the House takes up drug pricing and well could be a feature of the House plan. There is a proposal that has been introduced by Congressman [Lloyd] Doggett [of Texas] that has more than 100 co-sponsors. That may or may not be what the House moves on, but it certainly is a signal that many House Democrats want to do something to give the secretary authority to negotiate prices. And this is an idea that polls very, very highly, according to Kaiser polls.

**Rovner:** Well, so Medicare never really very far away from the top of the health care agenda?

**Neuman:** Not really.

**Rovner:** Tricia Neuman, thank you so much. We will have you back again.

**Neuman:** Thank you, Julie.

**Rovner:** OK, we are back with Joanne Kenen, Paige Winfield Cunningham, and Kimberly Leonard. So, Joanne and I are old enough to remember when covering health policy in Washington actually meant covering Medicare and sometimes a little bit of Medicaid thrown in. Medicare was the 800-pound gorilla. Whatever Medicare did, private insurance generally followed. But even though it seems like Medicare is taking a back seat to, shall we say, sexier health care issues, a lot of those issues actually end up circling back to Medicare, which is why I wanted to talk about it. Take drug prices. A lot of the debate has to do with the cost of drugs to Medicare patients, right? Paige, you've been writing about this a lot.

**Cunningham:** Yeah. So this is a discussion that comes up from time to time because, of course, Democrats turn to it as one of the biggest things they could say that would be a force in lowering drug spending in Medicare. But it's been prohibited, as outlined earlier, by law for the HHS secretary to negotiate directly with the drug companies. And then the Congressional Budget Office has also said a number of times this wouldn't necessarily save the government money. But it really depends on what it would look like, and it could look a lot of different ways. So when you talk about negotiation, this could mean that … There's all kinds of questions around what types of drugs would the HHS secretary be able to negotiate. Is it just high-cost drugs? Or is it just drugs that have been seen large annual increases? And then there's questions around would the HHS secretary be able to set formularies.

**Rovner:** Lists of drugs that would be covered and therefore a list of drugs that would not be covered.

**Cunningham:** Correct. And that's a really important … That would be a really important component in giving the government really leverage over the drug companies. Otherwise, it might not really have a lot of teeth in these negotiations. And there's a lot of ways that you could formulate this, too. You could, of course, have certain drugs that would be negotiated in the Part D plans. Or you could have a public option sort of a thing where the government actually administers its own drug plan, where all the prices are negotiated in that plan. And then maybe that plan serves as sort of a competition with the other privately run Part D plans to push prices down there. So when we talk about negotiation, it's not just one thing. There's a lot of blanks that would have to be filled in here.

**Rovner:** But this has been a big issue for several years now, right?

**Kenen**: Since 2003.

**Rovner:** Yes. Right, since they passed the Medicare drug bill. Now, of course, the other piece of Medicare drugs we talk about Part B drugs. Now that we've talked about what Part B is and what Part D is. Part B are the drugs that are basically administered by doctors in their offices or by other health professionals in offices. And that's a big issue in drug pricing, too.

**Kenen:** And they tend to be very expensive. There are some generic chemotherapy agents that are not that expensive. But when you hear about these whopper drugs, these whopper prices, they're often the ones that a doctor gives you, that you don't go home and swallow. They're IV or infusion, injection, or whatever — they offer it in a health care setting. And that's one of the areas

that the administration has been looking at and, so far, discarding many ways of bringing down prices. Not all. I mean, there are things that are still on the table. But the whole issue of any kind of formulary, or this is in and this is out, is politically really difficult. And any time they've even tiptoed around categories of drugs or reducing how many are in a category, Congress on a pretty bipartisan basis says, "No, you can't go there." I thought one of the interesting points Trish made in the interview we just heard was that instead of a formulary, maybe you just say, "Well, here's some other goody that you in Medicare," which is such a huge part of our health care system, "unless you" — Julie's here, we'll make it a puppy story — "if you're a corgi, you don't get your bone unless you do something on drugs." So there are other ways of pulling other levers, which is something I hadn't actually really thought about much. That was an interesting way to think about it.

**Rovner:** And, obviously, I mean, the politics of Medicare are still pretty intense even though there are huge political discussions going on among privately insured people who can't afford their coverage. But seniors vote and seniors are on Medicare for the most part. Is that not …

**Kenen:** And seniors take more drugs.

**Rovner:** And seniors take more drugs.

**Leonard:** Yeah, and that's a big part of it, too. And it's just that because the Medicare program is so fragmented [and] because there are so many different parts to it, what people are actually paying out of pocket can be really significant, even year after year after year. And so that's why it's always been an area that politicians have at least talked about addressing even if they haven't been able to get the clout behind really reducing drug prices for Medicare beneficiaries.

**Rovner:** All right. Well, I want to talk …. Another piece of Medicare that's often in the news is fraud. Obviously, health care fraud is not just a problem in Medicare, but fraud in Medicare comes directly at taxpayer expense, so the federal government pays particularly close attention to it. I'm sometimes surprised there isn't more attention paid to Medicare fraud these days

**Kenen:** Except by Sen. [Chuck] Grassley [of Iowa].

**Rovner:** That's … Exactly. That's a good point. I mean, what are some of the things to look at if you're actually looking at Medicare fraud?

**Kenen:** Well, I think [if] a certain entire state seceded, it would solve the problem. But I think it's not unique. It's huge in Medicare and Medicaid because they're huge programs and they're centralized programs and huge government programs. And they have offices and a strike force with the Justice Department, and some of the busts they've made have been mind-boggling amounts of evil genius money. I guess they're not so genius because at least they do get caught.

**Rovner:** Eventually.

**Kenen:** Yeah, but we also don't know how many more out there that don't get caught. I mean, there's abuse at home care, there's abuse in everything.

**Rovner:** I just got a press release or actually we did a story — now Congress is working on it — about a scam where people are going to senior citizens and trying to get them to take genetic tests so they can steal their identity, among other things.

**Kenen:** That was a great story. But these big frauds that are like billing for dead people or people who don't exist or patients you don't have — the made-up people fraud — some of these big busts. But there's also subtler kinds of maybe not fraud, but it would be fraud in the eye of the beholder — the government would call [it] fraud. And the doctors say, "I just have a lot of sick patients." What is called "upcoding," where somebody comes in and you might categorize them as having this severity and get 100 bucks or you categorize them as having that kind of severity and getting 500 bucks. So that happens. And I think that if we did go to a Medicare for All system or any other kind of public thing, upcoding can still happen. It's very hard to legislate greed away. And I may have told this story before. When my mother went to the dermatologist, they only did half of her body, and they said she had to come back with the other half. And so stuff like that happens, where people get excess care that doctors can bill for, or nurses or other practitioners. So that's another kind of … whether you call it fraud or you call it waste or you call it abuse or you call it bad medicine or you call it … whatever you call it, it's under the fraud umbrella.

**Cunningham:** And that's part of why we've had this push toward paying for quality of care and not just quantity of care, as we've seen through the innovation center at [the U.S. Centers for Medicare & Medicaid Services].

**Rovner:** I'm so glad you brought that up.

**Kenen:** You paid her to say that.

**Cunningham:** So that's something, of course, that was created under the Affordable Care Act. And it's been an increasing part of the conversation over the last few years of how do you bundle payments together for episodes of care and incentivize all the providers to work together for this set sum of money so that they can minimize the number of services but in a way that actually serves the patient. It's been pretty slow going, I think. And some of the bundled payments haven't always resulted in the right set of incentives. And so there's a lot of tweaking that's going on there.

**Rovner:** And they've also resulted in a lot of pushback from the people who used to get paid more for doing these things.

**Cunningham:** Right. Yeah, because this … well ultimately the hope is … I guess it's twofold. It's that it will result in better care, but that also that it'll achieve some savings for the Medicare program. And so this is a big part of it in trying to realign those incentives for physicians.

**Kenen:** Right, so those practices that we were just talking about, the upcoding, making people come in twice when they could come in once, unnecessary care. By changing the payment structure, as Paige was just talking about, you change the incentives, those things. You might still be a greedy individual, but it would be harder to exercise your greed. But it's very slow. I mean, the American health care system is almost a fifth of our economy. The fee-for-service system is how it grew up over decades. Medicare was very much designed as a fee-for-service system — with we pay X for this and Y for that — and moving away from it, it's difficult both in terms of how

to technically create systems that are really the right … If we're talking about quality, what metric do you use? How do you measure quality? Who's deciding? You know quality when you see it. Different doctors disagree on what quality care … The diabetes should be at this level or that level? There are all these technical problems. And reducing costs means somebody's making less money. So there's a huge amount of political pushback.

**Rovner:** But it's interesting that CMMI — which is technically the Center for Medicare and Medicaid Innovation, which was created in the Affordable Care Act — was created basically to do these experiments, these payment experiments, within mostly the Medicare program to see if they would then be scalable to the rest of the system. So it's another example of how Medicare is being used to lead the rest of the health care system in innovation. But it's been really controversial. Yes.

**Kenen:** Well, except it's the one thing they never … I mean, of all those however many Obamacare repeal votes we had — not just in 2017, but in the five years before that, when we had smaller, you know, "let's get rid of this, let's get rid of that" — there was really never an intense assault on CMMI. There were occasional letters from now-retired Sen. [Orrin] Hatch [of Utah], but there wasn't really a massive push to get rid of CMMI. Despite all the political warfare, that was one thing they did have some bipartisan agreement about that: "We do have to get away from fee-for-service. We do have to figure out how to reward value and incentivize value. It's better for patients, and it's better for the taxpayer."

**Leonard:** And it's something [HHS] Secretary [Alex] Azar has really embraced, too, because …

**Kenen:** Much more than [HHS] Secretary [Tom] Price.

**Leonard:** Yeah, exactly.

**Kenen:** But even Price didn't try to get rid of it. I mean, we thought that when the Trump administration came in, they might try to get … There was a lot of speculation that they'd try to get rid of it. But they realized they could use it. Secretary Price wanted to use it in different ways than Secretary Azar — they're both Trump appointees.

**Leonard:** He's a doctor, and he was opposed to mandatory …

**Rovner:** He didn't like doctors getting paid less. Is what it turned into.

**Leonard:** Yeah, exactly.

**Cunningham:** Because there's this controversy over whether doctors should be required to participate or whether it should be voluntary. But Sylvia Burwell, who was the ...

**Kenen:** Second HHS secretary under President Obama.

**Cunningham:** She had made this a really, really big focus and had outlined some like pretty major goals, and then they seemed to be on hold. But then Secretary Azar has also announced some goals. I'm forgetting the exact percentages, but I think he said he wants to move to at least 50% of

Medicare payments based on quality by some date. And so I think it's something the administration is pursuing and sees value in.

**Kenen:** And there was a law that replaced this old broken doctor payment formula, the so-called “doc fix,” which was really …

**Rovner:** Oh, it was in MACRA [the Medicare Access and CHIP Reauthorization Act of 2015], right?

**Kenen:** Right, MACRA. I said we weren’t going to use acronyms!

**Rovner:** I know. Sorry. 2015.

**Leonard:** But even that has gotten watered down a little bit because of the pushback from the doctors.

**Kenen:** But in terms of Medicare, it's a very technical bill. But it encourages all the things that Paige was just talking about in terms of value. It changes how doctors are paid under Medicare, which as Julie began this conversation, drives much of the health care system. Private insurers, some of them are very innovative. But this whole push with Medicare starts paying doctors to do things differently. It has a ripple effect through most of the health care system. So this 2015 law, which has a confusing acronym — which Julie said and I'm not going to — it does really push the health care system and particularly Medicare in ways that could prove to be very, very significant over the years.

**Rovner:** Well, it completely rewrote how Medicare pays doctors. That was the main part of it.

**Kenen:** Right. But that is like … Obviously, the ACA takes up the political oxygen. This other 2015 bill, MACRA, which I just said, has a big effect on Medicare, which will then have a big effect on — and not in ways that patients will necessarily understand or see, but it aims to pay for good care.

**Rovner:** So most of the policy fights around Medicare have to do with …

**Kenen:** Money!

**Rovner:** Yes, providers and how they're paid. Occasionally, there's one that actually focuses on the patients themselves. A big one that's been on the back burner for several years is something called observation care, which has to do with when Medicare patients who are in the hospital can get care in a skilled nursing home. It can hit patients really hard in unexpected ways because many of them don't know that they were actually not admitted to the hospital but were there under something called observation. I guess first we have to reiterate what Medicare doesn't doesn’t cover when it comes to nursing home care. It doesn't cover most of what we think of …

**Leonard:** It doesn’t cover nursing home care. Yeah. And a lot of people are surprised to learn that. Yhey think, “OK, this will be something that's covered.” Medicaid will pick up some of that cost, but you really have to deplete all of your assets in order to even qualify. So with observation care, a patient is being allowed to stay at the hospital but not formally admitted.

**Rovner:** And often they don't know the difference.

**Leonard:** Exactly.

**Kenen:** The really big thing is Medicare, as we just said, does not cover nursing home, long-term care home care, for forever and ever, just sort of custodial long-term care as people get frail or have dementia. It does cover — is it 100 days?

**Rovner:** Yeah.

**Kenen:** A hundred days of skilled nursing care. So that if you've had, say, hip surgery and you need to be in a skilled nursing facility, which is sort of a variant of a nursing home, or a wing of a nursing home, or a form of a nursing home, or a rehab center of some type, or certain kinds of home care that are covered by Medicare — you have to have been in the hospital for three days.

**Rovner:** You have to have been *admitted* to the hospital.

**Kenen:** So being in the hospital under observation versus being in the hospital as an admitted patient. So it's not just copays and deductibles of the hospital stay, it's you're on the hook for ...

**Cunningham:** This goes to which part of Medicare is being billed. So under Part A, the inpatient care in a hospital is billed under Part A, and that's fully covered. But if you're in the hospital under observation care, that is billed under Part B, and there is a 20% copay for that, so it's sort of twofold.

**Kenen:** But [Part] A isn't 100% covered.

**Rovner:** It's 100% after a big deductible.

**Cunningham:** Right. So, but OK. But so if they're in the hospital under observation, it's sort of twofold. So they're on the hook for more cost if they're in the hospital under observation care. And it's also the case that they aren't eligible for this longer-term care or sort of not really long-term care, but long …

**Rovner:** Technically, it's called skilled nursing.

**Cunningham:** They're not eligible for that unless they've been in the hospital for three days under the inpatient, which is covered under Part A. So it's sort of like a double whammy for them.

**Kenen:** It can really be a huge amount of money.

**Cunningham:** Anybody who's going to age and enroll in Medicare should be listening to this podcast. That's the moral of the story here.

**Kenen:** Or be immortal.

**Rovner:** Yeah.

**Kenen:** And healthy.

**Rovner:** Yeah, very healthy. All right. Well, OK. So we've been talking about elderly people, and that's how we primarily think about Medicare. But there are millions of beneficiaries who are

younger and several million with kidney failure, who were specifically made eligible for Medicare in 1972. Just about everything the Trump administration has done on health care has been incredibly controversial, except for the kidney care initiative it unveiled earlier this summer. Somebody remind us, I think we talked about it at the time.

**Cunningham:** Can I just say, so I didn't know this about Medicare, that kidney care or dialysis is the only service that Medicare pays for for everybody. It doesn't … You don't have to be someone who qualifies for Medicare to get Medicare to pay for your dialysis.

**Rovner:** You just have to be diagnosed with end stage renal disease.

**Kenen:** And when they did this in 1972, they had no idea. I mean, life expectancy was different, and disease trajectories were different.

**Cunningham:** Without as many diabetics.

**Kenen:** You didn't have as many people with diabetes and other reasons for kidney failure. People live longer; they live sicker. And so when they passed this, the reason they passed it is that nobody could afford dialysis unless you were Bill Gates, who was only 10 years old at the time — something like that, 20 maybe. So it was really inaccessible, and it was smaller. So they passed, they did this one carve-out on this one disease, where we are going to cover kidney care because nobody can afford it. But you'll die without [it].

**Cunningham:** Can I just say this raises the question of why insulin isn't paid for? Because you could argue …

**Kenen:** But now there's cancer. I mean, you were not covering cancer.

**Rovner:** In 1972, people could afford their insulin.

**Cunningham:** Well, this is true.

**Rovner:** Medicare didn't cover drugs, either.

**Kenen:** Right. There was no drug coverage. So, there is this carve-out. But the fact is — does anyone remember the number of people on dialysis? I don't remember off the top of my head, but millions that Medicare is paying for.

**Cunningham:** It's like $80,000 a year — what it costs Medicare for one patient.

**Kenen:** I have not heard anyone who doesn't like this policy.

**Rovner:** And there are a number of different pieces of it, too, that would basically improve care for people with kidney disease.

**Kenen:** Home dialysis — which I didn't understand until … it's something I just never learned about. I mean, there are two different ways of having dialysis. One is you can go through, you can like sleep at home. It's through the abdomen.

**Cunningham:** One is like really disruptive, and one is like pretty non-disruptive. You can do it at home versus having to go in.

**Kenen:** You can even sleep through it. You can like sleep hooked through this other form at home and get up and have a much more normal life because being hooked up to a dialysis machine at a center for several hours three times a week is really debilitating and you can't easily work around it. So (a) it lets people do this at home, (b) it gives them a choice of two different ways of being treated, and it's still covered. There are more incentives for kidney transplants because it's not a minor operation. It's a big operation, so it gives more money to help people get through that period if they become a kidney donor. And there also are all sorts of other incentives for improving the care of kidney patients.

**Rovner:** So I want to go around the table. Medicare, as I said at the top, used to be anything that health reporters in Washington covered. It was practically everything. Now it's less so, but it's still ...

**Kenen:** I don't know, Julie. I think maybe you've covered Medicare more than I did. I mean, we covered a lot of other things.

**Rovner:** Yeah, but on the Hill, it was mostly about Medicare policy. Medicare sort of still not as big a deal as it was, but still a big deal. Yes?

**Kenen:** Julie, Clinton care, Obamacare.

**Rovner:** I'm talking about before that.

**Kenen:** I wasn't here yet.

**Leonard:** It's still a very big deal. But I think one thing that has grown so much is the interlacing of the private sector with Medicare and all of the people that are increasingly enrolling in these publicly funded privately run plans, the Medicare Advantage plans. We have what a third of beneficiaries now that are on these Medicare Advantage plans? And so, that kind of mixing up of the public and private sector can complicate some of the messaging heading into 2020 about Medicare for All. We even saw Kamala Harris come out with a plan that would say, "Well, we do Medicare for All, but then we would also keep Medicare Advantage for all." So, that adds a whole other layer, and you brought up fraud earlier. There have been a lot of questions about whether there has been overbilling from some of these different health insurance companies, and it's become a boon to health insurance companies to really partner with Medicare and also Medicaid.

**Kenen:** It's very profitable. When people talk about insurance companies making a lot of money, that's where they're making a lot of their money.

**Cunningham:** I think one of the ways this whole thing gets [complicated] … is when I realized that Medicare Advantage is conceptually very similar to the marketplaces because the government is subsidizing private plans. And the politics of it just get so interesting because when you look at the politics of Medicare, in general, Democrats tend to be the cheerleaders for traditional Medicare, and Republicans love to tout Medicare Advantage as a success of doing things through the private sector. But then it all totally flips around when you look at the Affordable Care Act, and it's been

Republicans that, of course, as we talked about many times before, love to slam the marketplaces, but it's a really similar thing. So it's just the politics of it are so weird when you actually understand the policy.

**Kenen:** Medicare Advantage didn't take the first time, which was in the late ’90s. And what was it called, Julie?

**Rovner:** Medicare+Choice.

**Kenen:** And they're both Part C.

**Rovner:** That wasn't even the first time. It goes way back to the ’80s.

**Kenen:** But that was before I was here, so it doesn't count. It didn't take off until its second, or perhaps as Julie just corrected me, its third or more …

**Rovner:** I think it was like its fourth iteration.

**Kenen:** And it really has taken off, and it does have more bipartisan support now, particularly if you are a senator from Florida. People like it. I mean, the one-third of Medicare beneficiaries who are in it are largely choosing — sometimes there's a retirement benefit that you don't have a choice — but many people are choosing this. They like it because it's what they had. Before when Tricia talked about this …

**Cunningham:** It's simpler, too.

**Kenen:** You can get dental, you can get vision. I mean, there are reasons to do it, and it's quite popular and has a constituency and it's thriving.

**Rovner:** Well, I hope if we've left you with nothing else, we've at least informed you that Medicare, that everybody thinks that going to Medicare for All would be simpler. Medicare is many things — simple it is not.

**Kenen:** And it has a way bigger private insurance component than many people realize, through Medicare Advantage, through the drug benefit, and through all sorts of technical administrative pieces.

**Rovner:** Yeah. But health care is hard, and we'll stick around to try and explain it. So that is our show for this week. Thank you for listening. If you enjoyed the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review — that helps other people find us, too. Also, as usual, you can email us your comments or questions. We’re at whatthehealth@kff.org. Or you can tweet me. I'm @jrovner.

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**Rovner:** We'll be back in your feed in two weeks, on Sept. 5. In the meantime, be healthy.