

**National Academy of Social Insurance:
Getting Involved in Medicare Policy & Medicare: The Basics
July 14, 2006**

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PAMELA J. LARSON: I am Pam Larson. I am the executive vice president of the National Academy of Social Insurance, and you know something of our National Academy because you registered for this by coming online, onto our website, and you will be hearing about probably what makes us the most unique of the non-partisan public policy think tanks in Washington in that we have a very talented membership of the nation's experts on social insurance. By now, you probably know a little bit about what we call social insurance. In Europe, it is a very common name for programs that we pay for while we work, to protect us when we can't work because we have retired, we have lost our job, we have become disabled, we have been injured on the job, those kinds of things, and in the U.S. we call them Social Security, Medicare, unemployment insurance, and worker's comp, but we also as a national academy of scholars are looking at all the unprotected risks that American families experience so we have done a lot of work on long-term care, on the poverty programs that you think of as Medicare, SSI, and also on the private insurance and private pension area, so we have in our national academy membership people around the country whose books you read, whose articles you read, you see them at conferences, you are taught by them at your universities, and we are really pleased whenever we can ask them to share what

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they know from their careers with the next generation of leaders in this area. That has been a goal of the National Academy since it began 20 years ago and we are really happy to once again offer this day long feast of ideas about policy and Medicare for you all and I think many of you know we have planned this as a two day event so on August 4th if you are still here in Washington on your internships, we invite you back for another day of Medicare academy.

So I am going to start with some housekeeping before I introduce our first speaker. First of all, we want to get a sense of how well we are targeting the information we give you so we know some of you start today with a lot of background and some with less and we would like you to complete what we have labeled the Medicare academy pre-test and I am going to ask my staff to collect this in a few minutes so if you would take a few minutes to look that over, again just whatever answer comes to mind is the important one. A little later on, we will ask you, we will collect from you the yellow sheet which is just a little demographic background on yourselves so that we know when we report out to our members and funders who we reached here as a group. Both things are totally confidential. The reason we have a number on the pre-test is that later at the end of the day we will ask you to complete the post-test, the same quiz, and we

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want to be able to match yours with yours. So please take a couple of minutes to do that. Thanks.

Okay I can see by the stirring that many people have finished. When you are done, just put it in the center of the table, a pile there, and then our staff will pick those up. Thanks again, and we will pick up the yellow sheet a little bit later.

Now I have the pleasure of introducing our first speaker. She is in demand as a speaker and will have to leave us right after this talk, but we are really happy that she chose to spend some time with you this morning. Maya Rockeymoore is a researcher, she is an advocate, she is a communicator and commentator, and she now has her own consulting firm Global Policy Solutions. Her bio, along with the bios of all of our members that you will meet today, is in the packet in the pink, so I will just tell you that she brings to us very interesting experiences across the social insurance issues area, experience at the very powerful ways and means committee, Social Security subcommittee there, the National Urban League's policy institute, and the congressional black caucus foundation where she also began their policy institute. So Maya, would you tell our gathered why you are here today with us? Thanks. [Applause]

After making a run back to her car to get it, I just want to let you know she has written a very useful book

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called *The Political Action Handbook*, a "how to" guide for the hip hop generation, and that is sort of preempting a bit why we asked her to be here today. Thanks.

DR. MAYA ROCKEYMOORE: Thank you, Pam, and thanks to the National Academy of Social Insurance for gathering this. Last year, I had the pleasure of being here to speak to a group of you all last summer on Social Security. This year, it is Medicare, both very important programs in this country, social insurance programs. Let me tell you a little bit about myself and my background. I came to Washington D.C. just like you. I don't know if some of you are interns and some of you may be fellows, some of you still may be students, but I was a fellow with the Congressional Black Caucus Foundation when I came here. I came from graduate school and actually when I was in graduate school I also worked at a Marian County Health Department in Indianapolis so I came with a orientation towards health care but with that I worked on Capital Hill for several years, working on the house ways and means committee on Social Security policy. The house ways and means committee also covers Medicare policy and so with that, I also became very immersed in Medicare policy as well and continued that after I left Capital Hill and maintained that interest to this day. I am a member of the National Academy of Social Insurance and so with that I think it is very important that young people

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better understand what social insurance is, how it differs from other federal programs, and why we should all care. Why we should care, and that is exactly why we are here today to really understand in more detail why Medicare is important not only for the country but for each and every one of you and for our families and communities, and so with that, in the time honored tradition of David Letterman, I decided that I would do a top 10 list of why we should care about Medicare. Now, you know, excuse me if it is not as funny as Letterman, but it shouldn't be. We are talking about something that is very important, but the first thing is, you pay for it! How about that? [Laughs] You should care about something that you pay for and how many of you actually work and earn a paycheck? All right and so how many of you wonder what the deductions on your pay stub read? FICA, right, Federal insurance contribution act? Well guess what? A large part of that are your Social Security payroll taxes but another smaller part is your HI, your hospital insurance tax, and that, believe it or not ladies and gentlemen, you know you may have been wondering. I know I did when I first got my pay check, what is this FICA and why are they taking my money? But, they are taking your money in part because to fund the Medicare program, the hospital insurance trust fund, which funds the Medicare program and so every worker in this country contributes to that through their payroll taxes and

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so you pay for it and you should care about it because you pay for it. The second point I want to make is closely related to the first is that you own it. Unfortunately we are in a time in society where many people view government or big government as something over there and the people as something over here, well guess what? Government is the people. Government is you, and so to the extent that you pay for it and you own it, you should care about it, and so that is something that is very important to realize, but another very important thing to realize is that you all know somebody who uses the Medicare program. Can I see a show of hands of people who know someone on Medicare? Near universal, and I think that is a very important statement. If you have grandparents who are using Medicare for a large part of their health care needs, to meet their health care costs, you might know somebody who is disabled who is on disability insurance and they are drawing down on Medicare benefits. You may know somebody even if it is not in your personal family. There is somebody on your street, that elderly aunt or the person you pass every day on the street corner, is using the Medicare program and so with that it is very vital to our communities and to our society because it is providing benefits to almost, it touches everyone's lives in some way, and this is closely related to the whole notion of social insurance and that is the whole notion that we are all in it together,

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community values and so number four, community values is another very important point about Medicare as a social insurance program. We all pay for it, we are all in it together in terms of pooling our risk and we will all, if we live long enough or if we become disabled, we will all access Medicare, so community values is something that is important for all of our communities. Five, the benefits keep seniors from poverty. Now what do I mean by that? What kind of health insurance system do we have in this country? We have largely an employer based health care insurance plan in the country, meaning that the type of health care, whether you get health care at all, is dependant upon the type of employer you work for, right? So what happens when you age over time and you can no longer work? What happens? If we did not have Medicare and we live in a society that has an employer based health care system, and you can no longer work for an employer who can provide you with health care, you get to the age of 65 or whatever age you decide to retire, how do you get health care? How do you get it? Not only that, you are older, you have more health needs. Insurance companies as we all know, discriminate against people who have preexisting conditions. By the time you are 65, I guarantee you we are all going to have preexisting conditions, so the Medicare program provides a vital need. It provides a vital hole in our country and that is the fact that because we have

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this employer based health care system, the Medicare steps in to provide support, health care support for those folks who can no longer access health care through the employer structure and so it is very important to realize and that includes those people who become disabled as well, and that is closely tied to my next point, which is and I don't know if this is six, does anybody know? [Laughs] Six, it is the only form of near universal health insurance that we have in this country at the national level. We, as you all know, have more than 45 million people year round who are uninsured. That number goes up to 66 million plus for anybody who may be uninsured at any point in time in this country and as you well know, when you don't have access to health insurance, anything can happen. You can be, if you experience a health care need, you could literally be ruined financially because you don't have access to that health insurance, but what we have here is a form of near universal health insurance so that basically for folks who say, you know, universal health insurance can't be done, we have done it for the elderly population nearly and so you know, we need to recognize and value that it is important. It is an important program and it shows a pathway for how it can be done, even though you may not believe it should be done exactly that way. Another point that is closely related to that is the whole notion of financial ruin. As a student, I

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have been uninsured. As an adult, I have been uninsured, and I have [inaudible] when I didn't have health insurance because I was either between employers or whatever, I have stopped going to my step classes. I don't run as often. You will see me being very careful on the streets because any accident can send me to the emergency room which is going to cost you a couple of thousand dollars that you can't afford, right? And so the whole notion of Medicare being there to provide financial assistance to those folks who need health care is a very important factor, and also by the way allows each and every one of us to have a higher standard of living because, and we don't think about this, but closely related to the point I made previously that if we didn't have Medicare, think about it. When your grandparents aged, when your parents aged and they needed health care, who would have to pay for it? Young people, right? Well, if you care about your parents and your grandparents you would have to pay for it and so to the extent that we have a system that provides that financial support, individuals pay for it as they go in terms of their working career. That is a financial burden that you don't carry necessarily as younger people and so you have to realize that it makes you have a higher standard of living. Another thing is of course for those elderly people and for those people who are disabled, it actually provides a way for them to receive health care, a higher quality health

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care than they would have if they didn't have access to health insurance, and so with that notion it is also creating a higher living, you know, standards of living of course but life expectancies, excuse me, preventing premature death because people have access to health care to make sure that they stay healthy longer, and so Medicare is important in that regard.

For those who are history buffs, Medicare is also and those who care about equality in this country and the history of equality and inequality in this country, Medicaid also played a very important role in terms of the desegregation of America's south in terms of hospitals and Jill [Inaudible] has done some research that clearly lays out I think a very credible case for how the Medicare program and the federal dollars flowing from the Medicare program actually went to, you know, in order to access hospitals, in order for hospitals to access these benefits in the 60's when Medicare was created in '65, they had to show that they were not basically running desegregated hospitals, excuse me, because we have a history in this country where you know people of color, African Americans and others, would try to access health care and they could not in the mainstream hospitals and so with the Medicare program came the desegregation of American southern hospitals and so that is a very important I think facet of history here, and the final thing I want to

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say that sets the stage for what you will be talking about today, and I think it is a very important point, and I think it is a point why all of you all are here, is that policy design matters. Now we can talk about how great Medicare has been in terms of raising living standards or raising life expectancy, etc, what it does for communities, what it does for individuals, what it does to keep individuals from extreme poverty, but the fact of the matter is that you can design policy, Medicare policy in such a way where you can undermine the program, or you can design it in such a way where you can create a very strong and robust program. Now those who have other policy intent may design Medicare policy in a way that makes it seem weak and bloated and ineffective and inefficient, and then they will point to the Medicare program and say look, you know, it is not working. That is why we should all go to private health insurance, even seniors, and so you have to realize there is a big policy debate going on. It has been going on for quite some time and there are various facets and factions and sides to this policy debate, so with that the design of Medicare policy matters, and you can design it to be very, very good, and you can design it to be very, very bad, and so you should care about his because you all as aspiring policy advocates, as aspiring policy, perhaps policy makers, you all have a role to play in ensuring the continuity and the strength of

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Medicare to make sure it is there for yourselves and your children and your children's children from here on out, and with that, Pam, I am done. Thank you. [Applause]

PAMELA J. LARSON: Thank you very much, Maya. Well, I think she gave you a very full story of what you are going to now deepen through the day today and on August 4th, and we thank her for being with us this morning. Now I am going to complete a couple of the housekeeping matters and that is please turn your cell phones to quiet and as I mentioned, in the folders there is a lot o material, some of which we will collect from you and some you will take home. I would like to just briefly go through that. The yellow form tells us a bit about you. Please, once you finish that, just put it in the center of the table. By now the pre-tests are done. A couple of times during the day I will ask you to note the goldenrod form, which is to give us feedback overall, it is two sides, it is the evaluation for the program, but it sometimes helps me anyway when I am at a day long seminar to look at it through the day. The speakers' bios, there are a couple of briefs that we are going to talk about in a second, but I want to mention, as I said the National Academy's goals to help develop the next generation of leaders, and you just heard Maya give a compelling case for that, in here we do have a flyer for our own summer internship program and I would like our interns this summer to raise your hands.

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Everyone sitting around at different tables, these are the NASI interns for 2006. We appreciate the extra time they are putting in to be helpers here and we hope that you will look at that. We have internship projects that address needs at the undergraduate, graduate, and even doctoral level each summer, and it is a paid internship. We also have a dissertation award for those of you who are selecting your dissertation topic, if it's in a broadly scoped social insurance area that is something that you can be nominated for as well. So other things about the National Academy are in that folder as I said but the most important things are our human resources and those who help us sponsor the events. We are a not for profit organization as is our partner in this event, the Kaiser Family Foundation. We really appreciate Kaiser's help. You are going to meet some of their talented professionals today, but this wonderful Barbara Jordan conference center is something that the Kaiser board realized was a real need in Washington to help those of us running non-profit educational seminars to have a really high class place to do these seminars in so please make yourself at home here and outside, as you noticed when you came in, we do have refreshments and that is where the lunch buffet will be set up. The bathrooms are straight out that door and to the left, and we invite you to feel comfortable here, to get up when you need to, and come back and ask

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questions as you need to and all of that, and again we thank the Kaiser Family Foundation for making this habitat for all of this possible.

Before we go into our first session, I am going to ask the person from the Kaiser Family Foundation who is responsible for helping us webcast this, is Sahara [Inaudible] there? Oh there she is, please do you want to come up and talk with them now? Great.

FEMALE SPEAKER (SAHARA): Hello. I am Sahara [Inaudible]. I work here in the online communications office at the Kaiser Family Foundation and I just wanted to give you all a brief overview of one of our websites, kaiseredu.org, and it specializes and is directly targeted for students and faculty of health policy to use in homework assignments, research, general academic use, and overall, so I wanted to give you all just a brief overview of all of the different tools and background information that we provide for you to kind of learn about health policy, understand the nuts and bolts of different issues, [inaudible] the topic, so we have these narrated slide tutorials that are done by various health policy experts. Patricia Newman has done a couple of them and I'm sure she will get into that with you later today. We have just updated the Medicare prescription drug benefit tutorial and they provide general background information and brief overviews of some of the major health

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policy issues today. You can see we have a long list of them. We have actually upgraded the way that we present them so they are a little bit more animated and more user friendly to help you just, it's almost like sitting in a classroom or a lesson and having a hands on experience and they are narrated so you can listen to them. I will run one for you real quick, just so you can get an idea of what it looks like. This is our consumer directed health policy tutorial done by one of our experts here, Gary Claxton, and you can click around to the different slides and they are also narrated. I have it muted now but some other tools that we have for providing background information on health policy issues are issue modules which kind of focus on specific health policy issues, topics that are sort of hot right now in the policy world, such as health care costs in the U.S. They provide links to resources beyond just Kaiser resources, key data, a list of key organizations, and also just a brief summary of what the topic is and why it is so important. For materials and background information on health policy topics that have a larger body of research and are a little bit more in depth and go back in time, we have reference libraries which also again provide key data, links to fact sheets from other organizations as well as some Kaiser resources, webcasts and presentations, and again a list of key organizations that present materials on that topic. For some

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of you all, one of the more important things is research, especially if you are still in school or get a research assignment at work. We have some pre-queried, our smart links tool has pre-queried searches on eight different topics in health policy, such as public health preparedness and what we have done is we have pre-queried about six different search engines such as the Kaiser Network Daily Reports, Google Uncle Sam, Google Scholar, PubMed, and you can see here the first three are syndicated, syndicate the first five results from the search, and if you just click on let's say for instance the PubMed search for public health preparedness, you will get the listing. We have already done the search for you and so it is just an easy way to get research from six different places just on one page, and if none of these are relevant to your assignment, you can type in a key word and do your own smart link search. I will just type in Medicare and we can see what comes up for Medicare, and you get of course over 32,000 results from PubMed, so you can see that we, you know, and this goes down the row from Kaiser Network and Google Uncle Sam, any government reports that are some news to a little bit of everything so it's just a great way to get research just on any topic that you are interested in, particularly health policy topics. We also have to kind of keep up to date with some of the news and other materials going on in health policy. We have links to

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the table of contents of some of the popular health policy journals. This is the *New England Journal of Medicine*, the *American Journal of Public Health*, and you can see the tablet of contents for the current issue and some of them provide free links to their articles. Some of them you have to purchase or go to the actual library and sift through it but this is a great way to get you started to kind of narrow down your resources, and since many of you are still in school or internship or fellowship programs, we also have a directory of policy fellowships and it is just a table organized by the sponsoring organization of fellowships or internships in the health policy field. The NASI internships are listed on this, alliance for health reform internships. This is a very popular resource for students and we encourage all of you to use it and it is constantly being updated so check back, keep it on your list of internship job hunts as you would with any of the other sites, and we are always looking to upgrade the site, to add more topics and we definitely want to hear especially from students and other health care professionals what they think are important, what you are studying, what is going on in the classrooms, to add into our site, so you can just send us an e-mail if you have a topic that you think should be covered by Kaiser.edu and we will try our best to include it and see what we can do because after all, this is a great resource for you all that we want to provide, so I

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have left some materials out in the front for you all to collect and take back with you and if there are any questions you can contact me or contact kaiser.edu at kff.org. Thank you. [Applause]

PAMELA J. LARSON: Thank you, Sahara, So kaiser.edu, what a great resource. All right now we will get into the substance of our morning, the basics of Medicare and it is my pleasure to introduce Reggie Williams who will be the moderator here and while he is talking I will make sure we get the power point up. Reggie is a graduate of our national academy staff in a sense. He came to us, he is a native of Columbus, Ohio, but he went to Brown University and graduated with a bachelor's in bioethics so he came to us and worked, learning about Medicare by doing a lot of work with our researchers on Medicare and long-term care and then moved to the Avolere [misspelled?] Health, the consulting firm here in Washington, where he has continued to work across a lot of different issues and worked with many of their teams as they have grown, and has some articles coming out now in *Health Affairs*, so Reggie, you will tell us about the session, you will tell us about our presenters. Thank you.

REGGIE WILLIAMS: Thank you, Pam, and thank you NASI. Today is going to be a wonderful educational experience for us all, and so we are here to focus on the basics of Medicare and we have two of the leading experts in Medicare policy and

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they are going to take us through the program, how it is financed, how it is structured, and all of those wonderful issues. The first speaker, Tricia Neuman, one of our gracious Kaiser Family Foundation hosts, is vice president for health policy here at the Kaiser Family Foundation and is director of its Medicare policy program. Prior to joining Kaiser Family Foundation, she was a Capital Hill expert on health policy issues. As a NASI member since 2000, Tricia holds a doctorate in health policy from Johns Hopkins University. She will explain the basics of Medicare, the program, and its structure.

Jack, the next panelist, will focus on financing and Medicare's financial and fiscal health in the future. Jack is president and CEO of the Alliance of Community Health Plans for the coalition of health plans striving for quality improvement. Prior to joining the alliance, Jack served in senior leadership positions at RWJ, the Robert Wood Johnson Foundation, and in the Dept. of Health and Human Services under the Clinton presidency. As a NASI board member and chair of the study panel on Medicare and Medicaid beneficiaries who are eligible for both programs, dual eligibles as we call them, Jack holds an MPEA from Harvard University and will be focusing on those issues today. Their complete bios are in your materials, so for reference please take an opportunity to look at them. We thank our panelists

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and without further ado, we are going to go ahead and hop into the basics of Medicare. We will hear from Tricia first and then Jack, and we will have Q&A to complete the session.

TRICIA NEUMAN: Okay thank you, Reggie, and thank you Pam. Pam is going to graciously turn my slides, so I get to sit here which is good because I think I can see more of you from this angle. It is just so great to see so many people who are actually interested in Medicare, so I am really thrilled that you are all here and welcome you to the Barbara Jordan Conference Center and look forward to our discussion about Medicare. My job today is to talk about the ABC's and now D of Medicare, which I am looking forward to doing. Just a little bit about Kaiser for a second, so you will understand the work that we do, we focus on health policy, but from the lens of the beneficiaries. So in Washington there are a lot of expert groups on different aspects of the health care system. There is the MedPAC, which is the Medicare Payment Assessment Commission, that focuses on reimbursement issues and many of you may have found yourselves working on reimbursement issues, particularly if you spend some time on Capital Hill. We really try to think about how the changes in the program affect the 43 million people on the program, so my talk might differ from others who are thinking about well how are hospitals paid, and how are doctors paid? That is not what I am going to talk about.

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I am going to talk about the structure of the program and think about some key issues for the people.

So if you could just turn to the next slide, so just starting with a little bit of history and a little bit of basics, stepping back, and Medicare was enacted in 1965 at the same time that Medicaid was enacted, the program that provides health care for low-income Americans and long-term care for older people. At the time that the program was enacted, it was just for seniors. It did not include the people who are under 65 and disabled, and it was enacted because there really wasn't another universal source of health insurance coverage for older people and about half of all seniors didn't have health insurance so there was a real need and an opportunity at that time for the program to be created. It was expanded in 1972 to provide health insurance coverage for people with disabilities. Not everybody with disabilities can qualify, as you probably know. You have to be receiving Social Security disability payments and then there is a two-year waiting period before you can get onto Medicare and you might say well why should there be a two year waiting period? That doesn't make a lot of sense. That is true. It is really a budgetary issue. I don't think anybody thinks there is a particular value in making people wait two years to get health insurance but at the time it was a way of expanding coverage and in doing so keeping the costs

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down. You might have heard about the donut hole, we will talk about that a little later. It is kind of a similar thing in terms of health policy. Sometimes you can't do something that seems right because you have budget constraints and I think that is another example of this. So now Medicare covers 43 million people, mostly seniors but 7 million who are under 65 and disabled. It covers people without regard to income or their medical history. So if you turn 65 and you otherwise qualify, the fact that you have a medical condition doesn't matter. You are automatically on. Medicare has four parts, which is why we are calling it the ABC's and now D of Medicare, and I am going to go through each part of them in a minute. I should say before going on to this slide that Medicare is administered by an agency called the Centers for Medicare and Medicaid Services, or CMS. As you may have heard, that agency used to be called the Health Care Financing Administration back in the days when Jack was working in the government but we are all getting used to this new title, CMS, to reflect a new mission and focusing I think on Medicare and Medicaid programs, so this next slide looks at the Medicare population and I think it is an important slide for any talk on Medicare, because it reminds us all about the diversity of the population and the diversity of the population is important to understand because as we think about changes that may be happening to

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Medicare, it is important to step back and think about well, who are the people who may be affected by these changes, because ultimately to make the program work it needs to work for people of all circumstances so starting sort of top down, as you can see, a sizable share of the Medicare population, 39-percent, have modest incomes or low incomes below 150-percent of poverty. That is about \$15,000 dollars for an individual. You may know that the Medicare drug benefit provides additional assistance to people with low incomes and that is the upper threshold that is included. Many people have serious chronic conditions and are in fair/poor health, about a third. Come down to the fourth bar though because this is probably the most important fact that I am going to give you about the Medicare population. About one in four has a cognitive impairment, such as Alzheimer's but maybe not Alzheimer's. Some kind of limitation that makes it difficult for them to do things like pay their bills, manage their own medications, or other more serious debilitations. That, I think, is really important because when we think about changes in Medicare and moving toward a more consumer driven health care system, even in Medicare, it is important to recognize that at least one in four people on the program are likely to need assistance from someone else if they are going to manage in a system that requires them to make important decisions about their health care and their health coverage;

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18-percent are dual eligibles. This is the group that Reggie mentioned before. These are people who are covered by both Medicare and Medicaid. Medicare is providing their basic health insurance. Medicaid is providing wrap around services and filling in some of the costs and providing benefits like long-term care. The coordination of these two programs has been something that has received a lot of attention in the past year with the drug benefit. We have talked about people who are under 65 and permanently disabled and of course, many are the oldest old, over age 85, and 5-percent, which is about 2 million, are living in nursing homes, so when you think about it, it really is quite a diverse population and any changes that are discussed really do need to consider how well will it work for people who fall into these different bars, because that is really the test of the success of any change.

Okay let's go to the basics. What is Part A? You may hear about Part A. It is the part of the program that essentially pays for in-patient services, mainly hospital in-patient services, also skilled nursing facilities. It pays for hospice care and some home health services. Part A services are subject to a deductible, which is a little bit over \$950 dollars this year going up to \$1,000 dollars or close to it in 2007. There are co-pays for in-patient stays after awhile. There are co-pays for skilled nursing facility

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stays. There is no co-pay for home health services, so as you will see that when people talk, and I will talk a little bit later about Medicare has high cost sharing requirements. Think about it, you know \$1,000 to go into the hospital is not an insignificant amount of money, particularly for people who are living on limited incomes and you know that a lot of people on Medicare are. Financing of Part A, any of you who are now being paid might know that you are paying a payroll tax for Medicare and Social Security. It comes on the stub. You see it on your stub. It is 1.4 or 5-percent that you pay and your employer pays the same amount of your wages that goes to fund Medicare services and it goes into a dedicated trust fund. Individuals are entitled to Part A if they or their spouse have contributed for ten years or 40 quarters, so if you guys are getting into working jobs, you will be starting to pay into Medicare and qualify when you are eligible.

Part B: Part B is the supplementary insurance part of the program. It pays mostly for physician services, out-patient care as opposed to the in-patient side on the Part A side, x-rays, diagnostics, a lot of the preventive care services are all covered under the Part B program. Part B services also have cost sharing requirements. There is a deductible that is indexed. In fact, all the co-pays that I mentioned in Part A you should know are indexed so everything

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goes up every year. That is actually a new thing with the Part B deductible. There is a coinsurance for physician services, a 50-percent coinsurance for mental health services, and again no home health co-pay. The issue of putting a co-pay on home health services is one that has gotten some attention but so far there is no home health co-pay. Part B is funded differently from Part A. There is not a dedicated trust fund per say. It is paid for from two sources. One is beneficiary premiums, which are now I think it's \$88.50 per month and going up to close to \$100 dollars per month next year, and also general revenues and in essence beneficiaries are paying 25-percent of Part B costs. General revenues, which are just general tax dollars, government dollars, are the remaining 75-percent. What is new about Part B comes next year when there will be a new income related Part B premium that has higher income people on Medicare, those individuals with incomes of \$80,000 dollars and couples at twice that amount paying more than everyone else does pay for the Part B premium. Individuals receiving Social Security at age 65 and who are entitled to Part A automatically can get Part B, and in fact if they don't want Part B they have to go down to Social Security and opt out. In this respect it is very different from Part D, the drug benefit, where people need to opt in. They need to make an affirmative election to get their Part D drug benefit. Part

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B works, you are sort of assumed to be in. You have to opt out.

Part C is the part of the program that refers to the Medicare managed care plans. Now Medicare managed care has been an option under the program since the 1970's but it has morphed. It has taken on new names over time and there have been new options that have come in over time so it used to be there were Medicare HMOs and they kind of went along and did their thing and pretty much 5-percent of the Medicare population was in a managed care plan for quite some time. During the 1990's, there was sort of a boost of interest and energy into managed care plans. They were renamed Medicare plus choice. There were new types of plans that were allowed, PPOs, private fee for service plans, and then again there was a legislation that changed the name. They were no longer called Medicare plus choice plans but now they are called Medicare advantage plans. I don't think these names have too much meaning in practice, but congress kind of thought they were re conceptualizing the program and giving more energy to the concept of managed care and each time they gave it a new name. I'm not sure beneficiaries know about that but congress knows about that. Medicare pays plans at capitated rate to provide benefits for each enrollee. That is a complicated topic and one that we could talk about a little bit more about how Medicare does pay the plans, but

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unlike Parts A & B, Part C is not separately financed so these Part C managed care plans are providing A benefits, B benefits, and most are providing the drug benefit but it is not separately financed. There is no trust fund. There is no premium, separate premium that is dedicated to Part C.

Today, nearly 7 million people are in managed care plans. The majority are still in the fee for service side of the program. There are strong financial incentives for plans to participate and for people to go into managed care plan that make them more attractive in terms of lower premiums and better benefits than fee for service, and HHS does project enrollment to increase as the next slide also shows.

Moving on to the very famous Part D in the next slide, this refers to the voluntary new Medicare prescription drug benefit that was enacted in 2003 as part of the Medicare modernization act. This hasn't actually been a new idea for Medicare. Congress and the administrations have tried for some time to pass a drug benefit. There has been discussion about it going way back to 1965 and there were task forces created. In fact, some of you may know that there actually was a drug benefit that was passed as part of the catastrophic coverage act of 1988, but it was subsequently repealed in 1989 so this is a long awaited benefit that has gone into effect this year. This benefit is structured very differently from other Medicare benefits in that for people

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to get this coverage, they need to enroll in private plans, either a stand alone prescription drug plan which is a plan that is offered by one of the large insurance companies out there that provides just the drug benefit, or from a Medicare advantage plan or managed care plan that provides all Medicare benefits, hospital, physician, and the new drug benefit, but there is an affirmative action that the individual needs to do mostly which is to decide whether or not they need a drug benefit and if so to choose one of these plans. Enrollment is voluntary. That was important politically as the issue is being debated because they didn't want to make this a mandatory benefit. It is voluntary but because, as you may know, there is a penalty for late enrollment and for those who haven't signed up that could be an issue and I think it is still an issue on Capital Hill. Beneficiaries who are eligible for Medicaid, the now well known dual eligibles that we have been talking about, it was not voluntary for this group. They were assigned to Medicare drug plans at the beginning of this year. Those who were qualifying for Medicaid who were receiving Medicaid drug coverage in 2005 were terminated from Medicaid's drug coverage, essentially on New Year's Eve, and transferred in to Part D plans, assigned to Part D plans by the government that went into effect January and there were significant issues, as you may have heard, about what happened to people

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when they went into plans and they didn't even know they were in their plans and the pharmacies didn't know they were in those plans that are being worked out to some extent.

Financing on Part D, beneficiaries pay premiums. There are general revenues and this year there is an interesting financing feature called the clawback which, it's not the technical term, that is not what is in the statutory language, but that is what the states are calling it and this is essentially requiring states to make a contribution, acknowledging that they were going to save money on drug expenditures on behalf of dual eligibles so there is a formula in law requiring states to make payments that contribute to the financing of the Part D benefit and that is called the clawback. There were controversies around the cost of the drug benefit, and as you can see the current HH estimates are about \$751 billion over a ten year period.

This is what the standard benefit looks like. There is a deductible of \$250. There is a coinsurance where the individual pays 25-percent, Medicare pays 75-percent, then there is the famous donut hole, and I am sorry this graphic doesn't convey it like a donut hole. We are just not quite that clever, but it is the gap between when an individual has \$2,250 dollars in total drug costs and \$5,100 which is actually \$3,600 dollars in out of pocket spending, not counting the premium, so it is kind of an unusual benefit

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design. As I alluded to earlier, it is simply because congress ran out of money and so the only way they could provide low-income subsidies and provide catastrophic assistance is to kind of cut out the benefit in the middle and then after that point there is the catastrophic benefit. Most plans don't follow the standard design, but most do have a donut hole.

I am not going to go into this slide in any detail but there are significant subsidies for the low-income population I think, whether you loved the drug benefit or hated it and opposed it, a lot of people think this is the most important part because it does provide significant resources to low-income people who sign up to get premium and cost sharing assistance.

This next slide comes from HHS and it just shows you where people are right now. There are about 43 million people on Medicare. About half of them are now in Part D plans. Many people are continuing to get coverage from their employer. As you can see, I am sort of moving clockwise around. Others are estimated to have what is called creditable coverage which is as good as the Part D drug benefit, which leaves about 4.5 million people without drug coverage at this point in time. There are a couple of observations I want to make about this pie chart and then I am going to go on because I think they will spend a lot of

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time talking about the drug benefit this afternoon. One is, you know, virtually everybody on Medicare appears to have drug coverage. That has got to be a good thing since that was the major reason why congress went through the exercise of creating the drug benefit. Two is 22.5 million people part in Part D plans. That is lower than what was projected by the actuaries. They were projecting 29 million people. That may or may not matter except if people who are in Part D plans turn out to be higher cost individuals than others, then it could have some implications for the premiums. It might also mean there would be fewer companies in the end because they didn't have as many people to sign up as they had hoped. Another point is that employers still play a key role so understanding the role of employers in providing retiree health benefits will continue to be critical because they are covering one in four people in the program and obviously the bright green, what is going on with the people who don't have coverage is a real issue. These are the people who could face the penalty for late enrollment and they don't have coverage.

This next slide looks at low-income subsidy participation that includes everybody who might get help including those who are the dual eligibles and what you can see and again, these are numbers presented by Mark McClellan who is the administrator at CMS and what you can see from

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this slide is about 1.8 million people have applied and are receiving the low-income assistance in addition to the duals but 3.3 million are not and there really needs to be a concerted effort to figure out where these people are and to help them get the coverage that they need because again this is the most valuable part of the drug benefit and without this coverage people will be missing out on something that is of critical importance.

Okay since we are going through everything very quickly, I am going to start to go through spending and financing and I will do even less on financing because I know Jack is going to cover that in great detail. When congress deals with the deficit, if and when congress deals with the deficit, it will be virtually impossible to make any significant headway without touching on the Medicare program because Medicare as you can see here is 14-percent of federal spending and if you look at the alternatives you can see how it gets pretty difficult to find another way to cut costs without running into major problems. Social Security is off limits, defense is a problem particularly at this moment in time, non-defense discretionary is an area where reductions often happen, interest is hard to impact, Medicaid is even more difficult than Medicare because of the population that is affected so deficit reduction generally means Medicare.

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That is something that will rise to the surface one day when deficit reduction becomes a priority.

The next slide shows you the allocation of the dollars. If you look at the \$374 billion dollars in benefit payments this year, what you can see is that Part A is about 40-percent, Part B, let's see if I can do the math really quickly, it looks like 34-percent, Parts A & B combined are 17-percent and what is new, just for you in this new slide, is the share of the budget that is now allocated to the drug benefit, which is 8-percent. This slide other than the drug benefit actually hasn't changed very much over the years. The hospital in-patient has been about a third of the total for some time. It will be interesting to look at the role of the drug benefit and affecting the distribution over time.

What this next slide shows you is that spending is not evenly distributed, so when people start talking about well, how are we going to cut the costs and what can we do to trim services for people, this slide tells you that there is a very small segment of the Medicare population, 10-percent, that account for more than two-thirds of all expenditures. These are the high utilizers. These are really sick people. These are people who are going in and out of the hospital. These are people for whom it is quite difficult for public policy to swoop in and make changes because they are using a lot of health care services, so I put this up because I think

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it is important for you to remember as you hear about how will we control the growth in Medicare spending? Remember that it is really a very small share that is accounting for most of the dollars. These are the people who are spending at least three times more than the average, or incurring that amount of Medicare dollars over the course of the year.

The next slide shows you, this is per capita spending and I think this one is interesting because many people think that as the younger, under 65 disabled population that tends to have the highest expenses. Interestingly enough, on a per capita basis, those who have disabilities or under 65 on Medicare, they incur actually less over the course of the year than seniors. That is in part a reflection of what Medicare does not provide that this population really needs. This was at a time when Medicare didn't pay for prescription drugs in 2002 but also many people with disabilities rely, use long-term care services, use equipment, and personal care assistance and that is exactly what Medicare does not cover in a major gap in the benefit package. There is one group, those with end stage renal disease who have very high per capita costs but they are a very small share of the population, only 300,000.

So far I have talked about program spending but I think it is important to understand that the program has gaps and that people actually do have significant out of pocket

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spending. In fact, Medicare pays for less than half of aggregate spending on behalf of the Medicare population looking at health and long-term care and premiums combined. Beneficiaries are paying about 19-percent. Medicare's coverage is limited, particularly in the area of long-term care up until this year in the area of prescription drugs. Medicare also by the way doesn't cover things that can cost money, like eye glasses and dental, hearing aids which are important to many people on the program. As I talked about earlier, Medicare has high cost sharing requirements. I am pretty struck by the fact that Medicare has a pretty high deductible. It is in essence a high deductible plan when it comes to people who need in-patient care and now of course it has a coverage gap for those who get Part D services, so while it is an excellent source of basic health insurance and now prescription drugs, people on the program are required to pay fairly high cost sharing requirements and premiums. That is why, at least for now, most seem to have some form of supplemental coverage. Employer plans, again, continue to be a key source of supplemental coverage. Medicaid is also filling the gaps, filling in premiums and cost sharing and paying for long-term care services. We don't know how many people today have MetaGAP. We used to say about a quarter of all people on Medicare have MetaGAP, but with the new drug benefit that may have shifted but we assume it is still a

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sizeable share of purchasing insurance outside of the Medicare program and employer plans and MetaGAP all come with premiums so it is not as if this additional coverage doesn't come at a cost.

This next slide shows you the distribution of out of pocket spending, or what are people paying for and again this was before the drug benefit. You can see that long-term care is really the main source of out of pocket expenditures which would affect a relatively small share but for that small share it would be big dollars. Prescription drugs accounted for one in four of these dollars, but I think it is important to say that quarter of the pie is not going to evaporate this year. Even with the drug benefit, people will continue to have out of pocket spending, and what this slide doesn't show you are premiums, which are not included here, which also are a significant burden for those on Medicare.

Fiscal challenges, I am going to really do this quickly because Jack is going to clarify everything that I am going to leave pretty vague and cryptic, but the real issue facing Medicare is that there will be fewer workers to support retirees as time goes on. Many people talk about the entitlement problems and they say what is wrong with Medicare and Medicare spending is growing rapidly, and just a couple of points I want to make, you know, this is not a Medicare problem. This is a national challenge because we do have an

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aging population. We do have more beneficiaries facing us in the future with fewer workers to support them. The effect of that demographic is being felt by Medicare and it is a challenge nationally to figure out how to finance care for an aging population but it is not really a Medicare problem. Medicare didn't bring on this problem and I think that is an important nuance that I hope you will understand because actually if you compare Medicare spending to private spending on a per capita basis, you will see that Medicare has done fairly well. In fact, Medicare per capita spending for identical services has grown slower than private sector spending so Medicare has been a fairly well run program, relative to the private sector over a long period of time and that is an important thing to bear in mind. You will hear about Medicare's crises. People will talk about it in fairly sensational terms. There are a couple of dull weather indicators that you will be hearing about. One is the trust fund and people talk about when is the trust fund going to go bankrupt or expire or go insolvent? They are referring to the Part A trust fund. That has been used periodically, repeatedly actually, to show signs of Medicare has got to get its fiscal house in order. Just remember that is an indicator. It is only an indicator for one aspect of the program and this number fluctuates so the left side of the slide shows you when the trust fund is projected to be

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exhausted, which is a term, it's a funny kind of a term but it means when the money is going to be running out. That number has changed over time and a lot of it depends on the economy because a trust fund is affected by payroll taxes. It also is affected by what congress does to slow the growth in spending for Part A services so you will see, if you look historically, you will see that the trust fund was actually supposed to go broke, I want to say in 2002 and obviously it did not, but that is something you will hear about. There is a new financial indicator that you also may hear about if you are working on Medicare issues next year. There is this concept of a solvency warning or a trigger that was put into law by the Medicare modernization act and that requires the Medicare trustees to sort of sound the alarms that there is a projection in six or seven years that the general revenues will reach 45-percent of total spending. This was the first year that the trustees made that announcement. They are projected to do it again next year. If that occurs, it will necessitate congressional action and the president will be required to submit a proposal and congress will be required to look at it. So there will be a drive to focus on financing and I think Jack is going to provide some perspective on how to think about all of that.

So putting it all together, there are a lot of challenges facing Medicare, not the least of which is

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monitoring and improving implementation of the drug benefit, which is a topic that I know you will be talking about this afternoon. Another challenge that we didn't have a chance to get into is setting fair payments to plans and providers and the concept of fair is highly subjective and what seems good for one provider doesn't always seem good for say the Medicare program, and so there is always a little tussle that goes on there. Balancing the role of traditional Medicare and Medicare advantage plans, that will be something to keep in mind over time. Managing care for the growing number of chronically ill beneficiaries, particularly those that account for a disproportionate share of spending, will be important, and finally financing care for an aging population and striking a balance between providing care for an aging population over time without shifting too much of the expense onto modest income beneficiaries who you see account for a relatively large share of the population, so I hope that is the ABC's and D's and we will be happy to talk about questions later.

JACK EBELER: Thank you very much. Tricia has made my talk very easy because when she sent the slides around, she really did cover all the basics so I didn't have to do the embarrassing thing one normally does when speaking with a Kaiser Family Foundation expert, which is go to the Kaiser website, pull down her slides, and use them to speak, which

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is what we would all normally have done, so based on her presentation and those 33,500 sites that were noted on the earlier presentation, after your review of those we are all confident that you will pass the follow-up quiz that Pam has mentioned.

It has given me the luxury of talking a little bit of some things that a couple of colleagues of mine and I wanted to talk to you about. Paul Jackson, who is at the middle table here, Carol Johnson and I at ACHP, we wanted to lay out a little more about how to think about some of the longer term financing issues connected with Medicare because they really are a long-term issue that drives the debate and if you work on these issues next year or you spend your career on these issues 30 years from now, you will be looking at and discussing some of these concepts so I am going to try to give a quick run through some of those in the form of some conventional wisdom versus reality but just by way of starting, when you get those long-term financing questions and social insurance programs like Medicare or Social Security, you are projecting out 25, 50, 75 years, and the issue becomes sort of what is the unit of analysis? How the heck do you think about what we are going to spend on Medicare in 2072 compared with what? And so the debate moves in a couple of directions that you will hear, and Tricia has set these up very nicely. One is this classic social

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insurance concept that you see in Part A of Medicare hospital insurance and you see in Social Security, and that is the trust fund concept where we worry about a percent of taxable payroll basically. There is a payroll tax that goes into a trust fund, the spending that comes out of that trust fund, and we worry about whether or not the trust fund is going to be exhausted. That is a great term, we finally got tired. We are all done now. And we start talking about the deficit in those programs as a percent of taxable payroll so that is one concept that you lay out here. The difficulty with Medicare of course is that a good portion of the portion isn't, payroll tax finance, isn't classic trust fund, Part B, Part C, Part B and Part D are not, so you have to get to broader concepts to really kind of understand these programs. That is where you get to this general revenue test that Tricia mentioned, you know, if 45-percent of Medicare comes out of general revenue the congress has asked for a little bell to go off as an indicator that there are some problems evolving. There is even more broadly how much of the national economy is devoted to these programs? So a lot of what I will be talking about is looking at these programs in the context of the gross domestic product and again looking out over many years and finally how much of the federal budget is allocated to these programs, or stated another way, as these programs grow, how much bigger will the federal

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budget need to be, and therefore how much would taxes need to be and you sort of get into some questions that way, so you end up with very large numbers here and tend to look at sort of the gross domestic product as a proxy, so that is the thing.

So conventional wisdom and some reality, we are going to start with Social Security. I know you are here for Medicare, but there is a lot of debate. We always hear about the politics of Social Security is incredibly difficult, congress and president, you know, nudged up against it this year, looked quite quickly and said no we won't be doing that this week, and the reality is Social Security, and this is a classic health care guy looking at other programs, those guys working on Social Security have it easy. The truth is Social Security is not analytically that hard of a long-term fix. Politically it is extremely difficult.

Here is a projection out of the last trustee's reports for Medicare and Social Security, over the next 80 years, just to pick a reasonable time frame by which we all think, and you can see Social Security in blue, increasing growing as a share of gross domestic product, again the dollar numbers here get so large as to become silly because they have no meaning to us today, but Social Security growing is a share of GDP up to around 6-percent. Medicare, which has always been a little less than Social Security, crosses

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over and continues to grow and grow and grow in the future, so that is quite a scary chart when people look at that and again, we are honing in first on Social Security. It's not quite as scary on Social Security. A second way to look at it, again, is as a classic trust fund program. Social Security currently has a payroll tax. I think it is 12.4-percent if you add up the employer and employee. The gap over the next 75 years, is about 2-percent of taxable payroll, so what that means is basically spending is projected to be about 14.4-percent of payroll. Taxes as currently projected are about 12.4 so we either have to reduce spending by about two percentage points of payroll or increase taxes by those two percentage points or some combination of the two. Difficult, but that is not a show stopper. It is about a 15 to 20-percent problem. A silly way to think about it is if I told you that you have to save \$100 dollars a money, \$1200 dollars a year for the rest of your life to do something when you retire and came back to you and said we have looked at the numbers and you don't have to save \$1200 dollars a year. Instead, you have got to save \$1400 dollars a year or you have got to do a little less when you retire. That is the order of magnitude of scaling the Social Security problem, so having done disservice to all of the wonderful experts who work on Social Security, piece of cake to work on that.

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Medicare, quite different, again sticking with the social insurance concept as a percent of payroll, this is the Medicare Part A trust fund. Here the actuarial deficit in red gets to 3.5-percent of taxable payroll over that same 75 year period. The payroll tax for Part A, as Tricia mentioned, is 2.9-percent so here you have got a much bigger problem and a bigger problem compared to the existing tax base, so that is the - oops, wrong button. I have now destroyed Kaiser Family Foundation's computer. [Laughter]

So Medicare is we think in general a more difficult problem. Second conventional wisdom, the issue is aging of the baby boomers. Absolutely there, I am a baby boomer. I am aging. [Laughter] I intend to continue to do so and the demographic realities are there, the so called dependency ratio changes. Tricia laid out the slides I think through 2030. They get more daunting through 2080. There are fewer workers working and paying payroll taxes to finance care for the elderly. So there are, that is more elderly as baby boomers age and in particular, while this doesn't matter so much for Social Security in the case of Medicare, as the elderly age more, when you end up in the year 2030, 2035, with more 85 year olds as well as more 65 year olds, you have an extra cost problem because 85 year olds need a lot more health care than 65 year olds, so there is a demographic issue here, but it is rising health care costs which Medicare

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pays that is the main driver of the fiscal crisis. Here again is Social Security as a percentage, EDP, this is looking at some CBO data that they laid out.

Parenthetically, one of the things I wanted to do with this presentation is flag some of these terrific sources. You cannot work on these issues if you do not read the Social Security and Medicare trustee's reports. Not the summaries, but the reports. They are very long. Paul Jackson knows I go crazy about this, and it has incredibly detailed tables and sensitivity analyses. The second terrific documents are by the congressional budget office which again lay out long-term projections in these areas.

So here again, Social Security look as a percentage of GDP, if Medicare and CBO presents a bunch of different scenarios, if Medicare spending grew and the one variable you changed was say, I'm going to have health care costs grow at the same growth rate as the gross domestic product. Basically have health care track GDP. This is what the Medicare line would look like. It wouldn't cross over from Social Security and it would go up because again there is an aging phenomenon that is an important fact there and it is a social insurance factor, but you may recall, go back, the trouble is health care costs don't track the growth in the GDP. Those of us in health care, I do this. We eat a lot of money, and we want more each year. This is going back. The

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original data point is 1953. We pick up some longer trend series in 1960, but health care unit costs grew faster than the rest of the economy before Medicare. They grow faster than the rest of the economy after Medicare and if you carry these projections out into the future, they continue to, so the underlying problem is health care costs grow faster than the rest of the economy for a variety of reasons, so you come back and you get to that solid Medicare projection that you looked at a couple of charts ago. The actual Medicare spending line doesn't follow that dotted line. It goes up, and this is a very rough and dirty analysis and the difference between those two is unit health care cost growth per person in excess of the growth in the rest of the economy and it is that gap, so that is why I would make the argument that it is health care costs, underlying health care costs, that one needs to focus on. It is not Medicare spending, and while there is a huge demographic reality here, it is when you get into these out years, it is health care cost growth that tends to be the big issue. So that is one.

Conventional wisdom, two, the answer to that is greater consumer cost sharing, and that is really the answer the private market is defaulting to right now, with greater deductibles, greater cost sharing in health plans. Difficulty, as Trish laid out, Medicare is sort of already there. They have been there. It is not a generous benefit

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package in the way that a large employer benefit package has been historically, so the tool that a lot of private decision makers are turning to is harder in Medicare in part because of the nature of the current benefit package and in part because of the nature of the population as Trish described it, and while we have clear evidence that higher cost sharing does save money, there is no question about that, as any researcher will tell you, it can be a blunt instrument and it doesn't do as much as some might say for the big curves. One of the most interesting things if you look at the change in the private health care market over the last 15 or 17 years, the line in yellow down there is sort of more comprehensive HMO and then the dark blue is more comprehensive point of service coverage. That was a period where the nature of your benefit package was expanding. That was actually a period where health care costs were pretty flat in this country, as I will show in a minute. Starting in the late 90's, we shifted more and more to PPOs which are where we use cost sharing more and more and then health care costs reaccelerated so again, the period there from 1993 to 2000 when health care spending is a percentage of GDP was actually flat for seven years was a period where we had relatively generous coverage, it is since then where we have increased other mechanisms of cost sharing that spending has gone up so this is not a major bullet by any means and again the

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Medicare population makes it a little bit difference. A third bit of conventional wisdom is that Medicare financing problems are intractable. You can look at these charts. You can look at Medicare and Social Security moving out as a percentage of GDP and throw up your hands, and I obviously hope that you all won't do that. There are a couple of things to say there. There are multiple ways to tease this problem apart. Congress has looked at this program periodically over the years. When spending goes bouncing up, the ratchets had backed down. In this environment with the charts we are looking at you can obviously need a much stronger longer term approach to looking at underlying health care costs. Again, it is health care costs that Medicare pays. It is not just Medicare spending. Looking at Medicare spending, and after you do that and hopefully hold those of us in health care a little more accountable for the dollars we eat, at some point you can't look at these numbers and not presume that some form or flavor of new revenues are going to be required. There are a lot of ways of looking at that. I am going to touch on a couple of them. One is that this is really not a big problem. It is a huge economy. It can absorb these kinds of increases. I will show you some data on that, and different political and policy folks have that in the back of their heads as they pitch ideas at you. Second, onto the other side, this is the end of western

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civilization as we know it. These programs cannot grow this big and it is a federal Medicare entitlement program spending problem and we have to attack it that way, look at it from that perspective. Third, and obviously a bit of a bias that I bring to it is that it is a health care cost problem nationwide in which Medicare is a combined participant and victim, and fourth is no big deal, that is why we have a tax code, and we will impose taxes. The difficulty of that approach, well not difficulty for me, is that this will really become a burden somewhere around 2030 when I am 80 and you know, I look around the room and I just don't think you guys are going to be that happy. Just sending me cash, which would be nice, but I don't think you are going to it, so there are a lot of windows through which you need to look at this and again, one of the things I always encourage people to do is as you hear folks talk, get a sense of their implicit window because it's as they are taking it, so one window is look, Medicare does grow a lot as a percentage of the GDP. This again is the CBO data, you know, that says six percentage points more of the entire national economy. Everything this nation does is devoted to Medicare over the next 50 year period, pretty big number. Well, GDP is growing during that same period of time, too, same data base. GDP in 2000 was about \$11 trillion dollars. I just love using trillion in a sentence. It is really kind of fun. And, real

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GDP, not nominal, real GDP is projected to triple over that 50 year period to \$33 trillion dollars and Medicare is the red down there so yeah, Medicare is a bigger share of the pie but you have got real GDP growth of \$19 trillion dollars sitting in there and about, you know, just a little bit of that is devoted to Medicare so the rest of the economy can still be incredibly robust. You are not making that many tradeoffs, you know, what is the big deal? And you do need to keep the growing economy in mind as you think about these programs over a long period of time. In fairness, if you are going to look at that, you ought to add in Social Security and Medicare and Medicaid to those same analyses and, you know, these programs now take up about 20-percent of the entire national economy in 2050, but you still get the real GDP growth in that period of time in other things of about \$16 trillion dollars so again, we spend about \$11 trillion dollars on other stuff today. Under this scenario, we would spend \$26 trillion dollars on other stuff in other things, so there is still a lot of money there, but you have got 20-percent of your entire economy tied up in three programs under these projections so that has got to keep that in context. The question becomes how do you lower the growth, rate of increase in health care costs? Again, I know we are on lovely Kaiser Network here and all of my members can tune in to this if they wish, but we cannot absorb increases in

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health care spending above the rate of the rest of the economy at the rates we are doing it now forever unless we can come up with some demonstrations of value that really convince the body populace that this is absolutely worth it and I want it so can we lower the underlying cost growth in Medicare spending as a result? Second, what level of financing and taxation is sustainable and who pays and how? Again, we can lower the rate of increase in health spending in this country. We flattened things for about seven years in the mid 90's. It wasn't real popular. Doctors didn't like it. Hospitals didn't like it. They talked to their patients. Their patients didn't like it, and when you in particular squeeze utilization and fees, it is very difficult but that is kind of a situation you need to be envisioning as you go forward into the future, not that model but that type of incredibly sustained attack on underlying health costs. A second way to look at this, again not necessarily the topic of what we are talking about but one of the things we know in health care and that is important for Medicare, is that higher, there is incredible variation in how much is spent on Medicare around the country. Some of the best data here comes from the Dartmouth team, and the basic and I am not an economist or statistician or anything so this is what will drive people, when you adjust for everything they know how to adjust for, they find enormous variation in how much

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providers provide to patients around the United States. When you roll that up at the state level, which is what this chart does, the vertical axis is the states' quality ranking, sort of what is the measure of quality and service in that state? The horizontal axis is annual Medicare spending for beneficiaries. If more spending were associated with better care, that regression line would be pointing up and to the right. It doesn't. It points down, and because we literally find in the United States in using Medicare data that the higher spending is not associated with better outcomes and in fact when they look at mortality data, I think the marginal analysis is an extra \$10,000 dollars, a marginal increase of \$10,000 dollars per capita in Medicare spending literally increases mortality rate by about 1-percent in some situations so when you think about health care costs and how one is to constrain this beast sort of, one of the wonderful opportunities is to look around the country and say gee, there are a bunch of states up in that top left corner compared to the bottom right corner that literally spend \$2,000 less per person per year of federal Medicaid dollars and so one question is exactly why are we basically feeding subspecialists to do extra and possibly unnecessary procedures in Miami and Louisiana? I can't pick on Louisiana anymore, and Texas, and as a result of those higher costs, dumping extra cost sharing on elderly people in Minnesota and

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the other states, so when you think about how to attack the cost problem, there are amazing opportunities out here but that require incredibly heavy lifting in dealing with over supply of specialists in some areas and over supply of hospital beds and unnecessary services and things like that, but the opportunities are out there to do that.

What about revenues? Again, you need to presume as you go out in the future on this a very comprehensive multiyear balanced attack on what do we do about underlying structure of health care and health care costs? What do we do about Medicare policy and Medicare program payments to lower the growth rate in that cost curve and get there? I don't want to be standing here saying the answer to this is more taxes, but it is hard to look at the numbers and say you don't have to produce some or financing in some flavor in some form as you go out there, so a little bit of the current picture, these are the sources of financing as a percentage of GDP, again, for Medicare for the next 80 years. The top line is the Medicare spending line again. The light blue at the bottom is payroll tax. That is the little HI program and the truth is that sort of stays pretty flat as a percentage of the total. The yellow is the beneficiary premium. They are in this and they are going to be in it more and more as we go out into the future. The red is the general revenue, again Trish mentioned the fact that the congress has sort of

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set a general revenue trigger when that gets 45-percent, which is presumed to be two years in a row, which is presumed to be next year, it triggers some look but that gets to be a pretty big share of the pie there, how much can you lean on that? The blue is the mystery, I mean the truth is that is the unfilled gap in the hospital insurance program and so when you think about financing for Medicare, the first thing you want to do is drop that blue line down, hopefully the growth rate in underlying health care costs and therefore Medicare, that will do something and hopefully we can be successful on that in the long-term. Then the question is given whatever line you have ended up with there, how do you pay for it? Make the yellow a little bigger, lean on the red, general revenues a little bit more, should there be a new form of taxation? I mean, you hear a lot of discussion of more consumerish taxes, value added taxes, consumption taxes, including taxes on health care services. But that becomes the question or sort of having arrived at some presumption of a spending line. How do you fill in the chart to actually make sure that you are financially liable over that period of time? The difficulty in the constraint is that this is looking at federal taxation revenues as a percentage of GDP for the last 40 or so years. The average is about 18.4-percent I believe over this period of time. We bounced in some incredibly good economic years up to the low

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20, went down to about 16 in a recent year, but when you think about these programs and if you sort of go back to that other chart where we showed Medicare, Social Security and Medicaid at 20-percent of GDP in the year 2050, that is basically the level of taxation that the body populace has found the maximum acceptable in recent past so really you sort of need to think about how much higher you can drive this line as part of that financing problem, and what is the way to do it in a way that is acceptable? I always leaned a little bit on the consumption side because it is incredibly regressive. So are premiums and uncovered benefits, but also it puts everybody in the same game. I think this issue where you have a world where young people are paying a payroll tax that old people are getting the benefit of is hard politics to manage as you get out into the different demographics we are going to see in the later years but you have got to sort of think about this as you go forward. I think that is all I have for you. Again, Paul and Carol and I would be glad to answer any further questions. I should have put Kaiser Family Foundation's website up here which is where we all go for more information as well as the other sources cited. Again, I think the CMS websites, the trustee's reports are just among them most boring things you will ever read but unbelievable amounts of detailed information and again the CBO projections as well for those of you pursuing that

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career, which I hope you will do because we need you to fix this. Tricia and I have worked on this for 20 and 30 years respectively and we screwed it up, so [laughter] good luck! [Applause]

REGGIE WILLIAMS: So thank you Tricia and thank you Jack. Let's give them another round of applause. [Applause] We are going to move directly into Q&A. We have a good amount of time here to discuss all these wonderful issues that people have brought up today and so kicking this session off, does anybody have any questions? Raise your hands. There will be a mic going around and please use that mic for your questions.

CHER: Hi, my name is Cher. I am a graduate student at the Goldman's School of Public Policy at Berkeley and one of the questions I have is about the rising costs of health care and I guess I am just curious. You see other technologies evolve and costs become more affordable as that technology becomes easier to reproduce and I am just curious as to why health care isn't following that trend and what it is about it that isn't equilibrating?

JACK EBELER: I am Jack. I am from Dickinson College. [Laughter] There is a very big literature on that. Again, I am probably not the academic expert on it. I think there are a couple of things. One is it is a situation where to the degree you rely on a market mechanism, it really is

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difficult in health care in part because my reading of the lot of literature, the dominance of the provider. You get a lot of supply induced demand. If you go back to the Dartmouth data I showed you in that state chart, their estimate is that about 43-percent of the difference in spending between the high cost, low quality areas of the country and the low cost high quality areas of the country is a different mix of physicians and hospitals. There tend to be more specialists, fewer primary care physicians, and more hospital beds in the high cost areas and as a result there is something like 43-percent of the difference is what is concerned sort of supply induced demand of discretionary services and what specialists and hospitals do is generate revenue for themselves so there is one issue of just what is the structure of the delivery system that is producing the health care good and service I think and the second is some of this growth has produced good things. I mean, there is, you know, health care has improved dramatically in the United States. I can do personal stories about my own parents or in general and so some of this is literally more robust services. We do get more for the health care dollar. I think the difficulty is most of us are convinced we are not getting marginally more for the extra health care dollar that we should so there is a big technological improvement, there is a supply issue, and so that is part of it. The other is I

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think the late Senator Moynihan used to talk about just the fact that it is a service industry and you see apparently in a lot of service industries the fact that you do not yet get the advantages of technological improvements which, when you really roll them through, mean many fewer workers doing the same thing. You don't get that technological improvement in a one-on-one physician encounter. A lot of folks are working on how to do that a little better in the future. I think that probably is a place we will see and get a little bit more. Trish probably has some [inaudible].

TRICIA NEUMAN: Trish and I went to Wesleyan about a little while ago. The only point I would add is there is some research that shows that while there are lots of advances in technology, they don't always produce efficiencies in that they don't always substitute for what was there before but they complement, so if you think about the progression from x-rays for example, people still might have an x-ray, but if that is not clear enough, they might have a CAT scan or they might have an MRI or a PET scan, so there is actually more services that can be used as a result of the introduction of technologies rather than fewer, and that obviously drives up costs, which isn't necessarily a bad thing for patient care. It just is not a cost saver.

REGGIE WILLIAMS: And thinking about that issue, I mean, and the value of health care services, I think some of

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the really important things that we are starting to see and we focus on these different policy issues moving forward is how exactly do we ensure high quality services helping people improve their health and lowering costs in the long-term future and I think we are really trying to deal with those issues. I think that is one of the important policy things that we are struggling with today. Next question?

FEMALE SPEAKER: Hi, my name is [Inaudible]. I am from South Korea but I am not familiar with American health care policy but today a little of you know some, I want to ask some basic, very basic questions that justify. One is [inaudible] Part A, B, C, D?

TRICIA NEUMAN: You are asking why is Medicare divided into these parts? [Laughter]

FEMALE SPEAKER: What is the difference between A and B and C and D?

TRICIA NEUMAN: We are going to have the older Medicare expert [laughter] do the older part of history.

JACK EBELER: So embarrassing [inaudible], it's maybe more history that we want but when Medicare was beginning to be thought of in this country, it was in the early 1950's and the only part that folks talked about was Part A. They were going to do hospital insurance and they were going to do it financed by a payroll tax and that was all they were going to do [interposing].

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FEMALE SPEAKER: Ten months ago, I came here so could you slow down?

JACK EBELER: I am sorry, I am sorry, so they were just going to do Part A hospital insurance. This was 60 years ago. In the early 1960's which is when Medicare began getting serious to be enacted, there was a big fight. A lot of people didn't want any Medicare program. A lot of people wanted a program just for poor people, and a lot of folks wanted instead, they didn't like a payroll tax and they said let's have a voluntary program that includes physician services, what we now think of as Part B, and do that instead of that terrible hospital thing, so you had this big political fight and the solution in our process and there is wonderful political science on this, is that they did all three. They passed Part A hospital insurance on the payroll tax for that political community that wanted that. They added in Part B as the voluntary program based on a premium but kept it voluntary because the doctors in America were convinced that Medicare would bring this country to ruin or bring physician income to ruin, one of the two, so they wanted to keep that separate and then they snuck in Medicaid to cover the poor, for the folks that wanted the poor, so that is the A/B history; D was added in just three four, 2003, three years ago, again as a separate part and because of the cost issues, keeping it voluntary and keeping it

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premium based so that it would sell, so the real answer is a lot of political compromises.

TRICIA NEUMAN: Let me just say for those of you who are history buffs, we have just experienced the 40th anniversary of Medicare and Medicaid and we have a video that is on our website which interviewed a lot of people who were around at the time including Secretary Califano who worked for President Johnson and if you are interested in the history, you can slowly watch the video and I think you might find it pretty interesting to hear about some of the compromises that Jack talked about.

FEMALE SPEAKER: [Inaudible] payroll, outpatient, inpatient [inaudible]. Did you catch my question, what I am saying? No? What is the definition of out of pocket and [inaudible]?

TRICIA NEUMAN: Okay I gotcha. These are just weird terms that are used. Out of pocket is the term used to talk about what people pay and we call it out of pocket because the idea is this is what you would pay out of your own pocket but it doesn't really have any other normal meaning but that is what the concept is. Inpatient is sort of inside the walls of the hospital, so inpatient hospital care or inpatient nursing home care, conversely outpatient is outside of the walls of an institution, like when you see a physician.

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FEMALE SPEAKER: Thank you very much. The last question is why is the age, why 55?

TRICIA NEUMAN: I think it is because it was the normal retirement age for Social Security so under Social Security you can retire early at 62 but you get full benefits at 65 and Medicare was piggyback, sort of thought up in conjunction with Social Security.

REGGIE WILLIAMS: Yes, please?

CARLOS: Yes, is this working? Okay this is a question for [inaudible]. I'm sorry. I am Carlos from the University of Texas, the School of Public Health Houston. I am a graduate student. Before Part D dual eligibles were receiving medications through Medicaid and Medicaid had some control of the prices because they used preferred drug plans, now Medicaid doesn't have a possibility and Medicare is not using it. It was part of the agreement for the implementation of Part D so the thing is some research says that it is a possibility that the clawback will grow so much and will be out of the control of Medicaid, that some states might just decide to cancel drug benefits with Medicaid, or at least make it paying, subsidizing part of the prices for drug coverage for the elderly or dual eligibles so do you think this will be a concern?

TRICIA NEUMAN: Well states are obviously very concerned about the clawback to start with, and there is this

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issue of states having fewer people to negotiate. They have less leverage as states in terms of prices so that is a concern that affects, because they don't have the 7 million people who they had last year and years before, so that is a concern. I know that prescription drugs are a voluntary benefit but all states are offering these benefits. I haven't heard that states are even thinking about eliminating the drug benefit. They may look and they are looking at ways to control spending. There is some interest in shifting costs on to Medicaid beneficiaries but eliminating the drug benefit is beyond what I have heard about, at least at this point.

REGGIE WILLIAMS: Any questions over here on this side of the room? In the red? With the headband?

MEREDITH BROIDER: Thanks. My name is Meredith Broider from Washington University in St. Louis, the School of Social Work, I was wondering if you all could, sort of getting back to the idea that the Kaiser Foundation, their focus is about the experience of the beneficiaries, as the Medicare program has gotten more complicated with multiple parts, it seems like it has grown so much and become such a less accessible program, I was wondering if you could talk about the experience of a beneficiary and if there is any evidence that services are utilized less or less effectively?

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TRICIA NEUMAN: Medicare has, at least historically, been a very popular program. Seniors love it. The general public has loved it, and I think one of the factors is that it has been relatively user-friendly. You turn 65, you get your card. If you don't go down and disenroll, you have your coverage. You take your card to the doctor, the doctor bills Medicare, the hospital bills Medicare. It hasn't been without problems. I don't want to paint a very, like a too idyllic picture, but it has been fairly user friendly. I do have some worries about the complicated nature of the program and that getting to a point where it is not so user-friendly and that beneficiaries have too much to do in order to avail themselves to the benefits that are out there. I think this first year of the drug benefit has been the start of the test to see how well beneficiaries have responded. What we have seen is that most people have ended up in a plan but we don't know whether the drug plan is really best for the people who are in it and you'll probably get into this, this afternoon. We have done some analysis that looks at the generosity of plans and what we have learned is that these drug plans really vary quite a bit and that for an individual to get the best possible benefit they have to make a decision that works for them because it depends on the drugs they take, the dose levels, the pharmacy, all that stuff that really affects the decision so you will see there are 1400 drug stand along

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plans and 1300 Medicare advantage drug plans, but people have kind of gravitated toward two companies interestingly enough, so even though there is this choice dynamic that has sprung free, at least for the first year you find people concentrating on Humana and AARP for their drug coverage. Whether or not those are the best plans, I don't know, so it may be that people make choices but they are not really rational choices that are based on the facts of their care needs and the coverage but more on what is familiar to them and that may not be best in the long run and I think as there is greater interest in moving this consumer driven notion to Medicare, it will be really important to monitor what the affects are going to be. I just saw that there is new interest in having a high deductible demonstration project for Medicare and with one in four people with cognitive impairments, fewer than a quarter ever going online, I mean that must be hard for everybody in this room to imagine because we like use the internet like it is our right hand, but one of our people on Medicare has never ever gone online even to write an e-mail and so the idea that they are going to be savvy manipulators of data and information to make good choices seems like a stretch and there is hope that family members will help them but in fact we see that seniors actually aren't asking their family members for help, at least with respect to the drug benefit, so I think it

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requires very careful monitoring because it could represent a fundamental shift in the program and it would be a real travesty to see the program go from one that has been successful and one that has enjoyed a lot of satisfaction to one that creates more frustration and maybe not the best health outcomes.

REGGIE WILLIAMS: Next question?

SARA GONZOLEZ: Hi, I am Sara Gonzolez. I am from M.I.T. My question is with, maybe this is addressing you, Jack, with the high cost of health care, the government can do a lot of other things necessarily besides just increasing taxes or anything else to decrease that high cost of health care, such as liabilities for doctors. Those are extremely high with everything that they do and also trying to decrease the number of uninsured people that are going into hospitals that are increasing the cost of high health care. Different other items that are just, those small ones but affecting all the small ones might also do something and I would just like to hear your opinion on that.

JACK EBELER: I agree. I think if you are going to look at this over the long-term, the key issue is to deal with underlying health care costs as well as just thinking about what the Medicare financing burden is, and there are a variety of tools the government has to deal with that and I would hope those would come in. The liability insurance one,

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there is analytic debate over whether or not and how much that will actually lower the rate of increase in long-term growth but if it shows that would do some things fine, again my view is you also have to get to the underlying supply issues. I would be the first person to say that covering the uninsured is not only a fiscal issue but a moral issue. You have to look at this as a series of structural changes in what we do across the board in government and as you say, the government has more tools than Medicare to deal with it, so I am completely with you. I think that is the kind of comprehensive thinking that folks like you really should be doing.

SARA GONZOLEZ: Just kind of continuing with that, it is a consumer driven market really and the government actually putting in different regulations would hinder that consumerism that so much defines America as we are consumed with lawsuits and with drug prescriptions and then selling and not giving on to generic brands and the huge debate with that, so do you really think that the government would ever try to hinder consumerism [inaudible - interposing]?

JACK EBELER: I think it is a hard place to be to say health care is a consumer driven market personally because I don't think the data show that but say more about what you mean by that? I am not supposed to be starting a fight here, am I? I'm sorry! [Laughter]

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SARA GONZOLEZ: I just mean because a whole bunch of drug companies are actually advertising to the people and people are going in and asking for those medications, such as Zoloft or other things like that. With the lawsuits, people are going in beyond and actually requesting these lawsuits for they are trying to do the whole consumer region thing with doctors and picking their plans and other things like that but I mean for doctors to buy a different piece of equipment or anything like that, the pharmaceutical companies and the biotech field, which is huge right now, are selling this. They are selling it. It's a very consumer driven high prices and the government could actually go in there and say you know, for all these medical devices that has to be this much revenue that you are going to get on this or for the prescription drug, for anything like that, and limit it. They could also do with patent law and like decrease patent law so that generic brands could come out there and be competitive in the prescription drug bill. There are a lot of things they can do to limit consumerism and the drive of revenues.

JACK EBELER: I appreciate you elaborating because I think it's a lexicon issue, at least in my mind. Again, I think those are the types of tools looking at patent, term, extensions; things like that are incredibly expensive as I think of it and it is just the communications issue. I think

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of those as supplier driven imperatives that, you know it is the vendor selling to the physician and advertising to the consumer who did not know they needed a wavy field of grain that shows up in that drug ad, but if there is a wavy field of grain there and I want one of them there pills. I don't know the answer to how to control underlying health costs. I think you are flagging what I hope everybody in the room takes away, which is you have to look at all elements of the health care system, you know, how we develop and distribute drugs, why people get this drug versus that drug, all these hidden incentives and government subsidies for high cost drugs and devices in some places, but I agree, those kinds of comprehensive things. Remember though there is also a, you know, hopefully there are a lot of good economists in the room. You do need to think also about when everything is completely insured, is it a free good and do people just go get a little more of it than if they had some incentives. So the issue on worrying about deductibles and coinsurance isn't that they are inherently evil or bad, it is how you calibrate it so that you get some of the incentives right but I am going to go back to your point and encourage everybody to think this way. You know, you need to look at the legal structure. You need to look at patent law. You need to look at all those things as you think about changing the underlying cost dynamics in health care in which Medicare

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participates as well as thinking about Medicare policy.

Thank you.

REGGIE WILLIAMS: There are lots of interesting questions so in the interest of time could everybody please limit their questions to one? Back table, there? Hand raised?

FEMALE SPEAKER: Mine is kind of just a comment about reducing the health care costs in general, and you guys can comment about it. We haven't really looked at just exploring preventative care a little bit more. I mean, if fewer people were getting sick then obviously there would be less health care spending so perhaps that is another angle besides write patent law and things like that. I just wanted to make that comment.

TRICIA NEUMAN: The only thing I am going to say about that is just to talk about something that is sort of an inside Washington weird thing which is what you are saying makes complete sense. You know, preventive services obviously are a good thing in terms of preventing future bad health outcomes. The weird thing, when you work on Capital Hill and your boss may have an idea for a preventive service that he or she may want to see the government pay for. What always happens when these bills get, any point that is considered somewhat serious is the congressional budget office, the gurus, the umpires of the federal budget weigh in

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and they say well is this going to cost money or save money, and so you being the good staff person that you are in Washington, you submit your proposal to the congressional budget office and you say well this is actually going to save money. Fewer hospitalizations, fewer falls, fewer nursing home admissions, what ever it is and the congressional budget comes back and says costs money, costs money, because they at least historically have not bought in to the argument that the additional cost involved in having the federal government pay for preventive services will net out savings over the long-term so any work that you want to do in your research capacity to help create an empirical basis for showing how preventive services will save money will be useful because that has been an obstacle in the past because in a very practical sense, CBO rings the bell and says no, sorry, it is a spender.

REGGIE WILLIAMS: Can we bring the mic over to the far corner over there and give those folks an opportunity?

MALE SPEAKER: [Inaudible] from Roosevelt Franklin University in Chicago, and my question is with the Part D government had tried to get the private sectors involved with the Medicare work and was it because you can save government's money if that was indeed the goal or has it been successful in terms of saving government's money?

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TRICIA NEUMAN: The main reason that the bill was structured to deliver the benefit through private plans is that there was a philosophical aversion to having the government provide the drug benefit directly because there was a real fear that the government would then start negotiating directly with manufacturers and there would be price controls, which was the biggest worry of the pharmaceutical industry and there was a worry that this would lead to a bigger government program. It would just pile on to Medicare which many felt was already too big so the compromise, the only solution that could really make it through the political process was to have a drug benefit fully administered by private plans. Again, turning to the congressional budget office, they actually have the view that private plans will do a better job in controlling the growth in drug spending under Medicare than the government would do if it negotiated directly and so they gave this approach a better score, a lower cost, than others that would have the government negotiate directly. Now that may or may not make any sense to you guys and you may think it is counterintuitive or whatever but CBO is the one that was driving the score and the administration agreed with that with their own actuaries. We don't know yet whether or not they are right or wrong. It is early on in the process. We really have very little empirical evidence to assess how well

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the drug benefit is working with respect to prices but that will be something that researchers will want to be all over in the next couple of years to see what the effect has been.

REGGIE WILLIAMS: Over here, down in the front, the gold.

JENNIFER SMITH: Jennifer Smith. I am at U.C. David School of Law, I was wondering if one of you could speak to the practical differences of people who access benefits through Part C and maybe what is the significance that people enrolled in Part C is going to be, or it is predicted that will be increasing, just on a general basis?

JACK EBELER: It is a relatively small part of the program. You have, I think Trish indicated around numbers 10-percent of the population has said I will be in a private plan that covers Medicare and supplemental benefits rather than in the traditional Medicare program. Remember that is a false choice. It's really the choice is usually between a Part C plan that does Medicare plus the things Medicare doesn't cover or they stay in traditional Medicare and buy a MetaGAP policy, so that is really the nature of the choice that folks have or they have employment based coverage so one thing is you get it all through one place. The analytics on that, a little bit of the history, a lot of folks roll into those plans because they retire into them. If you have been a member of your local health plan for many years as an

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employee and you turn 65, it is relatively easy to migrate into that Part C plan. Since you are getting everything through one plan, it is getting back to the question from the person from St. Louis, one of the big advantages is it could be less confusing because you only have one carrier and you only get one set of bills and the evidence right now that CBO puts on the table is the folks in those plans tend to be on average slightly, have slightly less intensity of illness than the average Medicare beneficiary but thus far it is a pretty small portion of the program. All those things are changing now. All of our analyses are based on pre-2006 data and January 1, 2006, we threw a drug benefit in the equation so it is going to be probably two years before the things sort out and we have a better look at sort of who is in a Part C plan that also covers drugs, who is in traditional Medicare with MetaGAP and no Part D, and who is in traditional Medicare and Part D.

REGGIE WILLIAMS: I have a follow-up question for you Jack in relation to that. Medicare Plus Choice combines A, B, and potentially D, and so are there opportunities for different types of care, quality improvement programs associated with that? I know Alliance does a lot of work in that area.

JACK EBELER: Arguably, I'm not here to pitch that, but if you have one comprehensive care system where

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everything is done together, you should be able to take advantage of both technology and the information you have got on folks to do things and I think the beneficiary confusion about I've got Part D and I've got a Part C and I've got this and I've got all these different forms is very real and it is also mirrored in delivery confusion. If your drug benefit plan is sitting over here, that is incredibly important data for your physicians, nurse, and care managers to have and if they are over here, so there is a potential to tie that together. The issue is can one actually take advantage of that and make it real and again that is presumably part of what it will take to do long-term quality improvement both in a private plan and I would argue in the traditional Medicare program because Medicare is going to get into that business really heavy at heart and they really need to do that.

TRICIA NEUMAN: There is another aspect to this. I completely agree that the idea of having one integrated plan for all your Medicare benefits has some real advantages if it works in terms of using information about your drug utilization to influence what physicians know and how it is they practice medicine, but in terms of broader implications, one of the things that has become clear based on some work that MedPack has done is because government is trying to encourage people to consider Medicare advantage as an alternative to fee for service Medicare, there is a payment

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differential now so that Medicare pays on average more for people who enroll in Medicare advantage plans than they would pay for similar people to be in the fee for service program. Historically, Medicare HMOs were thought of as a way for the government to save money. Medicare paid 95-percent of the traditional medicine, the fee for service rate, and it was considered a cost effective alternative. That is no longer the real objective here. The objective is to expand choice but because of the way that Medicare sets payments there is a cost to the government so that is an implication that needs to be considered because it has spending implications now and in the future.

REGGIE WILLIAMS: Right behind you.

HILLARY VONICORSI: My name is Hillary Vonicorsi [misspelled?] and I go to the University of Rochester, and the senate budget committee just passed the stop over spending act to potentially fix the demographic problems with Social Security and Medicare and you had mentioned when dealing with the deficit that it often happens that funding is cut from Social Security and Medicare and because of congress' reluctance to cut defense spending do you think that this is something that will actually help or do you think that it could just take away funds from these very programs?

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JACK EBELER: I'm embarrassed to say I don't know what the senate budget committee just did so I don't know what they did. [Laughter]

HILLARY VONICORSI: That's fine. I can't really explain it. It is really confusing but it says Senator Gregg, it's the stop over spending act, and it is to put caps and line item vetoes on the spending of congress.

JACK EBELER: Again, not knowing exactly, there is a mechanism that a budget committee can use that can in effect, think of the charts we just looked at and basically by [inaudible] say Medicare spending can't be above these certain levels and you in effect set a target for the programs that somebody else has to meet. On the one hand, there is the good news that the United States congress has increasing numbers of people that can do arithmetic and realize that we have a deficit. The trade off, the difficulty with that is it doesn't tell you how you are going to get there and it is comparatively easy to take any graph we drew and say Trish let's run that out at half percentage point health care cross growth compared to GDP and we would have solved the problem. The trouble is now what do you do? And how do you deal with it? You need to get questions like our colleague from M.I.T. was mentioning, what do you do about health care cost growth? How do you really attack this? What do you do with Medicare? The second thing is I

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would argue that is an implicit definition of the problem as simply a Medicare spending problem and again I think if you are really going to attack this long-term, I would encourage folks to think about it as an underlying health care cost problem, then a Medicare problem in spending, as well as a revenue issue, but I apologize. I don't know exactly.

HILLARY VONICORSI: That's fine. I agree with you.

REGGIE WILLIAMS: In the very back corner.

TAYLOR: I am Taylor from the University of Iowa, I had a question about, you talked about the over supply of M.D. specialists in some of the states with the lower quality measures but higher per capita spending for Medicare and you also talked about prescription drug prices and I was just wondering how you feel about some of the consolidation of some of these risk pools, because what we are really talking about, what everybody is kind of scurrying around is the issue of national health insurance and for the Part D benefit in particular, the companies that have most of the enrollees can negotiate really steep price discounts for prescription drugs and I am just wondering what you guys feel is the, I don't know, best way to go about the pooling of risks and getting price discounts, if that is a good thing or if we want to go back to managing care to control costs?

JACK EBELER: I'll take a crack at it. One, I don't think it is an either/or. Again, if you are going to change

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an underlying dynamic of health costs rising faster than the economy, you need to be thinking about structural issues in the legal system. You need to be thinking about unit prices, and you need to be thinking about utilization so I don't think this is a one hammer job as folks would have previously said. I have a personal bias that bigger risk pools are better than little risk pools because you don't want, particularly you don't want the private sector having its incentives and paying its attention to finding a good risk composition of folks. You want private sector spending their time on providing the best benefit they can for the dollar so I tend to lean bigger rather than smaller on risk pools.

MALE SPEAKER: Hi, my name is [Inaudible]. I go to George Washington University School of Medicine. I have a question for Jack. I don't know if I kind of grasped all the charts but I think I saw in one of them that for a period of time in the mid to late 1990's you mentioned that for about like six years, health care spending as a percent of GDP was constant, and you said nobody liked it because it was an unpopular thing they did, I was just wondering if you could kind of cap in a nutshell like what they did that kept it constant for a period of about five or six years, what some of the big measures are?

JACK EBELER: It was the two things the previous gentleman mentioned, people squeezed very tightly on prices

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and on price increases, real physician income declined during that period. They squeezed very tightly on utilization of services and you always turn first to inpatient services because there is where the biggest money is and those were the two big factors. The pushback comes because some of the squeeze was probably okay but nobody likes their income to go down. Some of it was inappropriate. You had both substantive and rhetorical stories, you know, folks not getting to the hospital when they needed to or having so many barriers to the need by which they and their physician wanted to get care but they just threw up their hands and both the substantive and political process rebelled. Large employers sort of said stop doing that and it changed but again anything comprehensive in this way, the answer to how do you do it is everything. It was price and use and again, some of that probably okay, some of it just not acceptable in the climate at the time.

REGGIE WILLIAMS: Could we go over here to folks at the back table? [Silence] Excuse me, could we check the microphone to make sure it is on?

DAVID: Is that better? Yeah there we go. Okay sorry. Again, I am David. I went to Cornell. I now actually work in the senate but I was wondering what lessons or what we could take looking at other countries experiences in health care and especially, I'm thinking more kind of

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Canada or Europe and whether or not we can take things they have done well and things they haven't done well and apply it to the U.S. context?

TRICIA NEUMAN: That is a good question. There really are two areas where I think other countries have taken the lead both because they are more philosophically open to doing different things than the United States does but also because of their population demographics and those are the areas of prescription drugs and long-term care. I think there is a lot our country, we haven't talked about long-term care today, but we really don't have a long-term care policy except we have the Medicaid program that requires people to be impoverished or spend down until they are impoverished to get Medicaid coverage in nursing homes and in the community, other countries do not impose such onerous requirements as a condition to getting coverage, and I think there is a lot we can do. We can look at for example Japan has done some interesting things in the area of long-term care, some of the Scandinavian countries. So long-term care I think we are so much at ground zero, at the starting point, on our long-term care policy. I think anything we can learn would be a step forward, and obviously this whole issue of pharmaceutical negotiations. Other countries have taken a very different tact than we have, and that is in part due to a philosophical difference. Our country seems to be philosophically opposed

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to being more aggressive at the pharmaceutical industry. Other countries are not quite in that boat, so while there may be lessons to learn, I am not sure there is a receptive audience here for progress in that area.

JACK EBELER: It's a very good question. I think a couple of things, one is somebody in the audience mentioned it earlier, most of these countries have just about everybody with some form of insurance coverage. I think arguably it is a little easier to deal with overall health care cost problems and then a particular problem like Medicare if you've in effect taken that off the table and can wrap so I think that is one thing. The big cost differences, I mean we spend more than anybody in health care by a lot. The big difference as Trish said, we pay more per unit of service. It tends not to be utilization. They have high utilization. We tend to pay more for everything ranging from a pill to a service and the income of the supply side in the United States is higher and it shows up most dramatically in pharmacy where the same company sells the same pill at a much discounted rate in other countries compared to us so that is one. They tend to adopt technology a little bit slower. They seem to catch up after a period of years but it tends to be a little bit slower in technology at [inaudible] and the third thing are administrative costs. We pay a great deal in this country. We value pluralism and public private mixed

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markets in this country and we think there is a long-term benefit to that presumably. We pay a bunch of money for it, so administrative costs in the United States are another place where I think we could look to those places and say exactly what are we getting for that and in particular in an era of technology innovation on business technology, not health care technology. You know, could the health care community adopt some of that and just save a ton of money, so I think those are some of the places for the analyses.

STELLA: Hi, my name is Stella. I am from M.I.T. and based on the slides that Ms. Neuman showed us earlier, she showed that 10-percent of beneficiaries are incurring 70-percent of the costs and I know from other reading that a large chunk of health care costs also comes from people six months within death and so it seems like to society this is inefficient, you know, the costs are much greater than the benefits we are getting from it, but where do we draw the line to say that this treatment isn't necessary or this treatment isn't cost-effective because the Terri Schiavo case seemed to be a tribute to the American mentality that we should extend life as long as possible and we are entitled to the best treatment available but if you do that then costs are just going to continue to rise uncontrollably so how are difficult decisions going to be made to say that not every patient is entitled to every possible treatment, and do you

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think that euthanasia might even be legalized to curve rising costs? [Laughter]

TRICIA NEUMAN: My friend Jack sits back.

JACK EBELER: The Kaiser Family Foundation speaks on euthanasia. [Laughter]

TRICIA NEUMAN: I think 20-percent of Medicare spending is for last year of life, just avoiding the issue for a second, so this last year of life thing is a real issue, and you touch on something that has broad ethical implications, medical care, you know, this is my own view. I think these issues are pretty hard to legislate in terms of public policy, and I think a lot of changes that occur really need to occur within medical practices around the country and sort of the theology of medical care. I don't think this is an area, I used to work on Capital Hill and this was a fact that came up periodically and the president of Hopkins Hospital came and he said what are you going to do, have a law that says you come in the door and somebody says yeah I think you have a 75-percent chance of being in your last year of life so therefore we are not going to provide certain services. It is obviously a very sensitive and difficult issue, but I think the sensitivity has to occur at the right site, and my own view is that is not in public policy, but that is really in medical practice with doctors and throughout the country and other caregivers as well, and I

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think it is cultural, and it is going to differ from across cultures within our country. As for euthanasia, I have no idea and no comment. [Laughter]

JAKC EBELER: You have to distinguish between the analytic concept and an actionable concept, because the difficulty is we don't know who is there and second, some people in the last six months of life or two days of life, if you include everybody in the room, you would agree that it was worth the effort for the intervention. I mean, there are some people for whom a dramatic intervention is medically, ethically appropriate, and it just doesn't work and they die, so there is a very complex population there. I actually think and I totally agree with Trish, this is a cultural issue, I think this is one where getting much, much more patient and family and consumer involvement in decision making is essential because your real ally in that in the long-term is people saying I don't want to go that way and a lot of people say that. It's just that they get into the clinical environment and all of a sudden the production line starts, and a whole bunch of things happen that individuals and family members didn't want. So I think that is very much a cultural issue. I actually have a slightly different cut at the Schiavo case, because I think in many ways while it headed in one direction for awhile, I think the cultural response to that actually was a little more in the order of

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respecting a proxy for what the legal proxy was for her wishes at that time, whether or not you think one part of her family should do it or another, but I actually thought, and the political process backed down real fast, so I actually thought that got the body politic educated in a way that is sort of interesting, but I think you really need to just push very hard to respect family and individual preferences there because I think that is your cultural ally in the long-term.

TRICIA NEUMAN: And I guess I would also say that I think families need help because people don't have a lot of experience making these decisions and you can almost envision a role for a caregiver that is not the doctor whose training is to save lives, someone to be an intermediary to sort of help both parties, the family and the medical community kind of come together and make some decisions at a time when everybody is very emotionally wrought as you can imagine, just to help sort of through.

REGGIE WILLIAMS: So I guess it all comes back to bioethics, I guess, college worked out. [Laughter] Definitely. Unfortunately we come to the end of our session here. We had many great questions and our time is ending here. Let's thank the panel and thank everybody here for their wonderful questions. [Applause] And, now I want to turn it over to Pam for food instructions.

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PAMELA J. LARSON: Thank you Reggie and Jack and Tricia. This was fabulous. Thank you all for those questions and please keep them coming. We are going to give you some time now to talk among yourselves about the issues that are important to you and with some of our academy members who can stay for lunch sitting with you at your tables. What we have is a buffet lunch set up out where the coffee and pastries were this morning so we would like you to probably instead of standing in line, go up table by table or however they do this at other socials and bring your food back here and our next session will start around 1 o'clock. This is an ideal time to take out that golden rod sheet and jot down some comments and some suggestions for us. It helps us a great deal in thinking about future academies and other activities we might undertake. Once again, thanks to our panel and Reggie Williams. [Applause]

[END RECORDING]