



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation<sup>1</sup>  
(Tip: Click on the binocular icon to search this document)

---

## **US Health Spending in 2006 Health Affairs January 7, 2008**

---

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING].

**MALE SPEAKER:** Good morning everyone. I'm here from Health Affairs to welcome you and to thank the Kaiser Family Foundation for giving this ... giving us this superior venue to do this and to thank CMS and to express the journal's satisfaction at a long term partnership in publishing these papers, which we do every year.

I'm going to take my cue from something that was in the editorial page of the Post this morning, if anybody noticed it, it was somewhat obscure and it caught my eye that in response to request for more information on flight safety, NASA was asked to release data from a pilot survey on safety. And the way that they did that was sort of at the 11<sup>th</sup> hour to dump 16,000 pages of raw data on the table and walk away leaving it to the consumer and the reporter and the scholar to digest it.

So we're fortunately not in that situation here and the reason we're not is because Office of the Actuary and the National Health Expenditure Accounts Team do this for Health Affairs every year, breaking down a lot of complicated information with a lot of moving parts, doing it in an intelligible and relevant way. So we're really thrilled, about doing this every year even though some people think it's my goodness why do you keep doing this, the numbers just change by small degrees but we know it's important, it's the most reliable data around. This is an election year; we're going to

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

be getting a lot of spin on a lot of the important policy features that are reflected in these data and these trends. So this is a place where you can come to get some kind of bedrock reliability that is free of agenda.

One final note for the reporters, the journal's ... because of the way it communicates with scholars, has become aware that in analyzing the impact of Part D there's some really serious constraints around access to data. It's all written into the MMA, you can look up the section then the Act that prescribes the very close holding of detailed claims and other data that CMS receives and it's generated by the Part D program which makes it really hard to analyze a lot of what's going on and opens the door to a lot of this manipulation of data. Now data that's available is the data that's voluntarily released. So as of, I hope that the ... that journalism community will help pry the door open in the months and years to come so we don't fly blind on the policy.

Without any further editorializing, so to speak, I would...

**MALE SPEAKER 2:** Actually before this healthcare presentation let me just add one quick reminder that all of the material presented is embargoed until 12:01 AM tomorrow, Tuesday January 8<sup>th</sup>. Just to make sure everybody's aware of that.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**MALE SPEAKER:** Gee, thank you. I was not for one.

Okay, after the presentation when you start questions, please identify yourselves because we are taping and the transcript it will be helpful to keep things sorted out. So we're going to have from each of the presenters identified on the screen here, pieces of the whole package, so we'll start with Aaron Catlin and this is going to be in this order that you're going to present. Cathy Cowan, Micah Hartman, and Steve here also. It's just going to be, you're going to kick it around.

**AARON CATLIN:** It's just going to be Cathy and I and then the questions, Stephen and Micah will probably join in.

**MALE SPEAKER:** Very good, which proves you don't need me to introduce you. [Laughter].

**AARON CATLIN:** Okay. Thank you for coming this morning. As we just mentioned, Cathy and I are going to present some of the major findings from the 2006 National Health Accounts.

Okay. This slide is an overview of the presentation. We're going to start by taking a look at some of the aggregate national health spending trends. Okay, the outspending share of gross domestic product. We're then going to get into some of the trends in prescription drug spending, the drivers of growth, some of the impacts from implementation of Part D on sources of funds and on sponsors of drug purchases. And then

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Cathy's going to present some of the trends in the healthcare sources of funds and the expenditures by service.

Okay, I'd like to start by putting health spending into context by looking at the growth trend for both national health spending and for gross domestic product. In 2006 health spending growth in the United States accelerated slightly increasing 6.7-percent and that's following growth of 6.5-percent in 2005. The growth rate in '05 to 6.5-percent, that was the slowest rate of health spending growth since 1999.

The growth in '06 was largely driven by increased spending by prescription drugs and for government administration, and net cost of insurance. As you can see in this chart, the health spending and gross domestic product have converged, their growth rates have converged in recent years and that has occurred as health spending has slowed and growth to nominal gross domestic product has remained relatively strong. This convergence has led to a stabilization of the health share of gross domestic product, which is displayed on this chart. And in 2006 the health spending share of TDP increased just one-tenth of a percentage point to 16-percent.

The health spending share of gross domestic product is an important statistic that shows healthcare spending in relation to economy wide output. Throughout much of the history, much of the early history of the national health accounts the health spending share of the GDP has risen

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

steadily. However in 1993 the upward trend came to an abrupt halt as the share of the economy devoted to health stabilized between 1993 and 2000. And that was largely due to the influence of managed care.

As that influence lessened health spending share began to increase as a share between 2000 and 2003 but then stabilized again between 2003 and 2006. Again, the recent stabilization is due to slower health spending growth and relatively high gross domestic product between '03 and '06.

After six consecutive years of slower growth and retail prescription drug spending it accelerated in 2006, increasing 8.5-percent and that's up from 5.8 in 2005. The implementation of Medicare, of the Medicare Part D benefit costs significant shifts in the sources of funding that paid for drug purchases. Public spending increased substantially at 34.1-percent and private payments for drugs declined by 1.3-percent.

In 2006 the trend in retail prescription drugs spending was influenced primarily by increased use, low overall rebates, changes in the mix of brand and generic drugs, and relatively stable price growth. The increased use of prescription drugs counted for about half of the growth in 2006, and that's compared to 20-percent in 2005. Some of the factors that contributed to the increased use include the implementation of Medicare Part D, new indications for existing drugs, increased

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

use of specialty drugs, and strong growth in several therapeutic classes.

Lower overall rebates from drug manufacturers also contributed positively to the trend in 2006 and there are several factors that contributed to this trend. First over six million individuals who were dually eligible for Medicare and Medicaid had their prescription drug coverage transferred from Medicaid to Medicare in 2006. And in '05 when they were covered by Medicaid there were Medicaid state laws that required manufactures to provide relatively substantial rebates for their drug purchases. And then in '06 under Part D, the rebates negotiated by the health insurance plans were generally lower than the mandated Medicaid rebates.

Conversely rebates existed in 2006 on purchases by Part D covered individuals that did not have coverage in 2005 and thus had no rebates in '05. When you look at these effects in that, it appears that the rebates for the dually eligible population have outweighed the increased rebates for newly insured enrollees under Part D.

The use of generic drugs, which on average cost 30 to 80-percent less than branded drugs, increased significantly in 2006 and that helped to restrain the drug spending trend. Generic dispensing rate reached 63-percent in 2006, and that's up from 56-percent in '05. And some of the reasons for the increase in generic use are the continued use of tiered co-payment

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

structures, the loss of patent protection for a number of brand name drugs in '06, and a lack of new blockbuster drugs. Also in 2006 drug prices remained relatively stable. They grew about 3.5-percent in both 2005 and 2006.

The implementation of Medicare Part D had a significant impact on the sources of funds that pay for prescription drugs and the share of drug spending increased, the public share of drug spending increased from 28-percent in '05 to 34-percent in 2006, while the private share fell from 72-percent to 66-percent. Now on this slide it's important to note that when we look at health spending by a source of funds, we include the Medicare Employer Subsidy and private health insurance. And the state pays down payments are included in Medicare rather than other state spending.

Now in a few minutes we're going to take another, a different look at spending and we're going to look at it by sponsor. And those two sources will then be moved to different categories at a sponsor basis. In 2006 Medicare share prescription drug increased dramatically from 2-percent to 18-percent, while at the same time Medicaid drug spending fell as a share of total drug spending from 19-percent to 9-percent in 2006. The decline in the Medicaid share was largely due to the movement of the dually eligible individuals from Medicaid drug coverage to Medicare Part D. And both private health insurance

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

and out of pocket spending fell as a share of total drug spending in 2006.

While the impact of Part D on drug spending was significant, when we look at the same pie chart but with total health spending you can see that the impact was more relaxed. This chart shows that Medicare spending in total increased from 17-percent share health spending to 19-percent share in 2006. Medicaid fell from 16-percent to 15-percent. Private health insurance also fell from 35-percent to 34-percent. And out of pocket spending fell from 13-percent to 12-percent.

Another way to analyze the implementation of Medicare Part D is to look at health spending by type of sponsor. And in the National Health Accounts we make a distinction between the sponsor and the purchaser of healthcare goods and services. Purchasers are the sources of funds such as third party insurers and out of pocket payments that we just looked at on the previous pie charts. Sponsors are the entities that sponsor the healthcare payments, and those would be businesses, households, governments, other private sponsors. This slide shows that the shares of total health spending accounted for each major sponsored category, didn't change much in 2006. However the implementation of the Part D did cost noticeable shifts within major sponsor categories.

So we're going to take a look at some of the major categories on the next couple of slides. At the aggregate

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

level, federal government spending accounted for about the same amount of health spending in 2006 as it did in 2005, 23-percent versus 22-percent. However when we look at federal spending within federal spending, we see that Medicare increased from 29-percent of federal spending in '05, to 34-percent in '06, while Medicaid decreased from 45-percent to 40-percent. And the shift within federal spending was caused in large part by the movement of the dually eligible individuals from Medicaid drug cards to Medicare Part D, which is the aggregate federal level that was largely offsetting as both programs are financed by general revenue.

Okay, now take a look at the state and local. State and local governments sponsored 17-percent of health spending in both 2005 and in 2006. However when we look at the details, state and local sponsor categories, we can see that Medicaid spending accounted for smaller share of state and local spending in 2006. That's 41-percent versus 43-percent in 2005. While state spending for other health programs increased from 23-percent share in '05 to a 26-percent share in 2006. And these shifts within state spending were due to the combined impact of the dually eligible population moving from Medicaid to Medicare, and to state phase down payments which were paid out of non-Medicaid state budgets, classified in other state and local programs.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Finally we're going to take a look at the household share of health spending which remains stable at 31-percent in 2005 and 2006. When we look at the detail we see that contributions or premiums for Medicare became a larger share of household spending and that's due to Part D premiums being paid for the first time. And at the same time out of pocket payments became a smaller share of household spending as more individuals had coverage through Medicare Part D.

And now Cathy's going to take us through some of the sources of funds.

**CATHY COWAN:** Thank you. I'm going to kind of switch gears a little bit right now, we're going to talk about the source of funds, the other sources of funds and services in health expenditure accounts.

And for the source of funds information, couple things, I'm going to concentrate mainly on the benefits [inaudible] of the services. So these are the actual payments made by these funding sources such as Medicare, Medicaid for the services that are provided. And in addition our slides will also be showing with and without prescription drugs, to kind of give people an idea of the impact of prescription drugs spending on these sources of funding. And to somewhat try to isolate what was going on with prescription drugs, not what's going on with the rest of the healthcare industry.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

These figures would relate to exhibit three in the article, so these are just kind of an expansion of that exhibit. First I'm going to start out with private health insurance benefit growth. And as you can see, when we include the prescription that private health insurance benefits decelerated in 2006. But when we include, but when we exclude prescription drug benefits, we see that there is a slight acceleration. The acceleration is primarily due to private health insurance payments, which accelerated in hospitals, home health agencies and nursing homes. If we look at overall private health insurance premiums, which is actually this number, plus any of the net cost of insurance, we see that private health insurance premiums also decelerated during this time frame, from 7.1-percent in 2004 to 5.5-percent in 2006.

Next we'll look at out of pocket spending. Out of pocket in the National Health Accounts is defined as co-payments, deductibles, and payments for services not covered by private health insurance, and also payments from health savings accounts. Again, decelerating growth when we include the prescription drug numbers, but when we look without the prescription drug numbers we see that there is actually a slight acceleration in out of pocket payments. This is probably due to private health insurance increased in US, private health insurance increased shift a little bit of the co-pays and deductibles to out of pocket spending.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Overall out of pocket spending in the last three years was less than the growth in DDP in income, therefore consuming less of the resources available. Also, when we look at the burden to households on an sponsored basis, which Aaron went over a little bit earlier, and include premiums for private health insurance, premiums and payments for Medicare, that household spending as a share of personal income has remained relatively flat.

Next well look at Medicare, and we'll look at the two major public sources, Medicare and Medicaid. Looking at the Medicare benefit spending we can see that without prescription drug or the impact of the Part D, we see that benefit spending in Medicare did decelerate in 2006. This was kind of the growth in most of the services provided by Medicare decelerated in 2006, this is one of the, there was also a decrease in inpatient admission in 2006 which influences the growth of hospital spending. For physician services there was a sore growth in the fee for service physicians, primarily due to the point 2-percent fee schedule increase in 2006.

When we look at Medicare and look at the two different programs under Medicare, Medicare Advantage versus the traditional fee for service plans, overall spending for Medicare Advantage grew 48-percent in 2006, two and a half times faster than in 2005. This is in part due to a 25-percent increase in enrollment in 2006. Traditional fee for service,

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

without Part D, grew 4-percent in 2006. It's acceleration from 7.5-percent in 2005 and the enrollment in the traditional fee for service declined during that period, declined 3.8-percent.

Next we'll go to Medicaid. As you can see, when we include the prescription drug spending Medicaid had the first deceleration in the program since its inception, and it declined 1.3-percent. However, when we take out the effect of the dual eligibles moving to the Part D benefit we see that Medicaid did decelerate in 2006 but still remained positive. Most services provided by Medicaid exhibited slower growth in 2006, as enrollment growth slowed due to more restrictive eligibility criteria and a stronger economy, and also as states continue cost containment initiatives.

Next we'll look at the services that were provided during 2006 and the distribution of those services. Over half of all spending pays for hospital and physician services. Prescription drug spending continues to be the third largest category of health spending, at 10-percent. If you look at this compared to 2005 there's actually been no change in the percent distributions for those two years. The other spending, which is 25-percent, includes spending for services such as dentist, other professionals, home health, over the counter durables, research and structures and equipment, among other programs.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

If you look at the growth by service categories, again as Aaron stated earlier, we can see that total NHE had a slight acceleration from 6.5-percent to 6.7-percent. But there was a broad based slow down in almost all the services with the exception of prescription drugs and the net costs of insurance, administration costs of insurance. Growth is the largest component of health spending, hospitals, grow slightly at 7.3-percent to 7-percent growth, which is \$648 billion. There was a slower growth in youths that was slightly offset by an uptake in prices.

Second largest component is physician and clinical services. It also slowed in 2006 to 5.9-percent growth and reached \$448 billion. This is the slowest rate of growth since 1999. Price growth slowed significantly, in part due to the Medicare payment update which was .2-percent and the impact of private payers somewhat following Medicare's lead.

Nursing home, which accounts for \$125 billion, also showed the slowest growth since 1999 and this, again, was also driven by a slow down in price growth.

Administration and net costs of private health insurance showed an acceleration of growth. And this is primarily due to the growth in Medicare administration and net costs of private health insurance, 60-percent of the growth is due to the implementation of Part D while the remaining

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

increase is due to the increase in Medicare Advantage enrollment.

In conclusion, there are several major points from this article. Health spending in the US accelerated very slightly in 2006, from 6.5-percent to 6.7-percent due to accelerating growth in prescription drugs and Medicare administration and net costs. But remains stable as a share as a gross domestic product. Retail spending for prescription drug growth picked up in 2006 after six years of slow down with the implementation of Medicare Part D benefit, which resulted in major shifts of who pays for prescription drugs. In contrast there is a broad based slow down across most of the major health services and health affairs in 2006. Thank you.

**AARON CATLIN:** We'd be happy to take questions. We're going to have a couple of our co-authors come up here to help us clarify the answer.

**STEPHEN HEFFLER:** Sure, I'm Steve Heffler. I'm the Director in the National Health Statistics Group, announced the actuary at CMS.

**MICAH HARTMAN:** And I'm Micah Hartman, I work for the National Health Care Statistics Group also.

**CHRIS LEE:** Do I need a microphone or just go ahead?

**AARON CATLIN:** Just go ahead.

**CHRIS LEE:** Chris Lee with the Washington Post. Just want to ask about the drug spending increase. So I want to

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

make sure I understand, it's gone up and the source of funding has shifted more to Medicare and government sources, but you said, I think you said the prices are, the price increase has not increasing any faster than before. So is it that more people are consuming drugs or is it that they're getting more expensive?

**AARON CATLIN:** The largest driver of the total prescription drug growth trend was use, which accounted for, I think it was about 50-percent. It was 50-percent of total. And the drug estimate that we have in National Health Council is just retail of drugs, so drugs that are administered in hospitals, or physician office, they're included with this type of provider [inaudible].

**CHRIS LEE:** Does that imply that just there's more coverage so there's more [inaudible] Part D [inaudible]?

**AARON CATLIN:** Part D had an impact on—

**CHRIS LEE:** [Inaudible].

**AARON CATLIN:** Part D had an impact on use, some of the other reasons that we list for uses that there was new indications for existing drugs. There was several therapeutic classes, I know hypnotics was one of the fastest growing. They're also contributed to the use, some of the categories and specialty drugs increased, their use increased at a rapid rate.

**FEMALE SPEAKER:** What are specialty drugs?

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**AARON CATLIN:** Specialty drugs are drugs that have to be delivered or administered in non-traditional ways. They, let's see, their either stored, distributed, or administered in non-standard ways and they're mostly, there's a lot of drugs for multiple sclerosis, cancer, rheumatoid arthritis, injectable biological, things like that.

**MALE SPEAKER:** What about hypnotics?

**AARON CATLIN:** Yes, the hypnotics showed fast growth in use in 2006. It was one of the fastest growing classes of drugs.

**MALE SPEAKER:** [Inaudible].

**AARON CATLIN:** Right, yes. They're like; some of the brand names are Lunesta, Ambien, sleep aid drugs, things like that. There's a number of other brand name drugs.

**JOHN RIGHTGUARD:** John Rightguard with CQ Healthbeat. I was curious what the actually Medicare outlays for drugs were in '06 and how that might compare with the projections that CDO had when the MMA came out.

**AARON CATLIN:** The total Part D spending was 41 billion, I'm sorry, 41 billion. The Part D benefits portion of that was 30, round it up to 36 billion, 35.6.

**JOHN RIGHTGUARD:** So any idea how that compares with some of the initial projections?

**AARON CATLIN:** I don't have those comparisons, we haven't looked into that.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**RICK FOSTER:** [Inaudible] I'm Rick Foster, Chief Actuary for CMS. We've been fortunate that the that the actual cost of Part D has continued to [inaudible] under what our earlier projections were hesitant primarily due to a couple of backers. One is, as we pointed out entire historical health expenditure articles, the growth in prescription drug costs year to year took a nose dive in 2004 and 2005. For more than a decade prior to that it had been in double digit rates year after year and then suddenly it reached down in the 5 or 6-percent region which [inaudible] made back in say 2001, 2002, 2003 where [inaudible] projections.

So that's been probably the biggest factor. The big part of that is this very substantial transfer to [inaudible] encouraged by the tiered co-payment system, et cetera for cost containment purposes. That's been a major factor in helping slow down the rate of [inaudible].

Beyond that, we anticipated a lot of competition with Part D once it was implemented. And we've built into our assumption about [inaudible] the price discounts and their savings for energy utilization. We built in certain models and statements from all of this. But as it turned out, the competition was even greater than we expected and the savings from these packages were greatly [inaudible] also. Those have been the chief expenditures.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**JOHN RIGHTGUARD:** So the '06 number is less than what CBO projected?

**RICK FOSTER:** I don't remember CBO's particular figure, but certainly less than what we had anticipated.

**FEMALE SPEAKER:** Does that include the loss of the rebates through the Medicaid program as state loss?

**RICK FOSTER:** No, this is for Medicare only.

**FEMALE SPEAKER:** I was thinking about the dual shifting over.

**RICK FOSTER:** Right, that's a very good question because the same factors that lower the Medicare costs, that we just talked about, also lowered the estimated savings from, federal savings Medicaid not having to pay for these drugs. So we don't have the ability anymore to look at the total federal costs, Medicare plus Medicaid before and after the law because we only have it [inaudible] now, but if you did that net overall impact wouldn't be as dramatic [inaudible] as it is just for Medicare alone. That make sense?

**FEMALE SPEAKER:** I'm just trying to figure that one out, because I thought earlier he had said that the loss of the rebates wasn't offset, that, I may have written it down, I'm trying to figure that out.

**RICK FOSTER:** Yes, ask me afterwards because rebates for what actually happened in 2006, that's one part that Aaron talked about, then you compare what actually happened in 2006

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

compared to the prior estimate, that's a different issue. I think the overall level of rebates is actually still a little higher than we had originally estimated even though it's lower than [inaudible], but then we estimated more recently [inaudible].

**MALE SPEAKER:** Cathy, you looked at the other spending category, are there any noteworthy changes by any service or product within that category?

**CATHY COWAN:** I don't think there's anything in particular noteworthy other than the fact that there was such a broad based slow down across all the services and mainly driven by prices.

**FEMALE SPEAKER:** Aaron, I think in following up on the overall rebate issue, and I understand about the dual shift, but are the Part D plans getting lower rebates than Medicaid did because of factors in how the Medicaid rebate, the best price is structure and the Part D plans therefore can't negotiate lower. And could that change with legislative fixes?

**AARON CATLIN:** Yes, the relatively low rebates in Medicaid were mandated rebates through state and federal law and in private plans in Part D rebates there were not as low, or not as substantial as the rebates in Part D.

**FEMALE SPEAKER:** Do you have any further assessment as to why that is the case? Is it just bad negotiating?

**AARON CATLIN:** I'm sorry, is it what?

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**FEMALE SPEAKER:** Is it just inadequate negotiating and therefore speaks to a different kind of negotiating system?

**AARON CATLIN:** We don't really get into looking at the actual negotiation and list that.

**RICK FOSTER:** I would just add that with a normal negotiation you have the pharmacy benefit manager, you have the [inaudible] this kind of volume and this kind of restriction, [inaudible] more favorable rebates, and all this has gone on for a long time and it's relatively inspected both in Part D and Primary Part D. On the other hand that doesn't really match or compare to what the state can do that passes a law and say before we get [inaudible] you may [inaudible]. That's not really a negotiation.

**MATT DEVISE:** I have a question about the spending by service category. I'm Matt Devise with Modern Healthcare. And I notice that there's been some declines in the hospital sector and also in the physician clinical services area, could you give some of the reasons behind those declines?

**CATHY COWAN:** You want to do the hospital?

**AARON CATLIN:** Yes, I'll start off with the hospital. Since 2002 it's been a very gradual deceleration. Still talking within the 7, 8-percent growth range, but in '06 it did slow it to seven, from 7.3 the year before. It's largely driven by slower growth in use, especially in patient use. And

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

then in '06 we did see an uptake in prices which offset that a little bit. Cathy?

**CATHY COWAN:** I was going to say, for physicians and clinical services it's mainly driven by the price growth in 2006, which I think was lower, around 1.8-percent growth in 2006. This was partially due to the low Medicare reimbursement of .2-percent in 2006 and then there was also indications that private payers were also following Medicare leads. But there was just an overall price growth deceleration.

**MALE SPEAKER:** [Inaudible]. Could you talk a little bit about what is the administration and net cost [inaudible]?

**CATHY COWAN:** Yes, the administration and net costs includes its – the administration net costs for private health insurance plans plus any kind of program administration costs, and this can include Medicare, Medicaid, all sorts of different types of the public payers. The main driver of that increase is due to the increase in the Medicare administration and net costs for those. As I think I said earlier that 60-percent of that increase for Medicare was due to the implementation of Part D with the remaining being due to the increase enrollment in Medicare Advantage plans.

**MALE SPEAKER:** Sorry, so you mean the, Medicare's administration of these healthcare plans?

**CATHY COWAN:** Right. It's the administration of these plans and the net costs of insurance for these private plans.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**STEPHEN HEFFLER:** So it includes both the government's administrative costs as well as the administrative and other net costs of insurance above the plans themselves.

**MALE SPEAKER:** How does that break down?

**STEPHEN HEFFLER:** How does it break down in—

**MALE SPEAKER:** Between the government and the private costs increases, is it mostly private cost increases? Is most of it attributable to the private plan administrative costs?

**STEPHEN HEFFLER:** Most of, is most of what attributable?

**MALE SPEAKER:** Most of the increased, the 8-percent...

**STEPHEN HEFFLER:** Yes. Yes. Most of the increase in the Medicare administrative costs is due to counting administrative costs under Part D, both the government administrative costs and plans administrative costs that previously were not counted because there was not Part D benefit. And on the MA side most of the increases switch from enrollees to fee for service to a MA world. The fee for service administrative, government administrative costs are relatively low percentage and that's your adding the net costs of insurance of private plans that once the enrollees switch from fee for service to MA.

**BOB ROSENBLATH:** Bob Rosenblath, freelance. Can you tell us what the government is spending per beneficiary on Part

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

D plan? How much it costs Medicare per person to run the Part D program, because you said that's the big increase.

**STEPHEN HEFFLER:** Yes, we can, we'll get you that number once we have it.

**FEMALE SPEAKER:** [Inaudible] the average benefit per Part D enrollees is \$1,703.

**FEMALE SPEAKER:** Could you repeat that?

**FEMALE SPEAKER:** Average spending benefit per Part D enrollee is \$1703 in 2006.

**RICK FOSTER:** That's slightly different from the question you asked.

**BOB ROSENBLATH:** Right.

**RICK FOSTER:** That's total value of dependent.

**BOB ROSENBLATH:** Right. That's what the governments spending on drugs per beneficiary.

**RICK FOSTER:** That would also be [inaudible] per expenditure.

**BOB ROSENBLATH:** Okay.

**RICK FOSTER:** That's just your premium, financing a good share of that. Likewise [inaudible] also. [Inaudible] find us something in the range of [inaudible] per person.

**CRAIG PALMER:** Craig Palmer, ADA News. You folks do this annually and you do it well, I mean significant changes in what you measure, how you measure, your tools, your techniques, anything new here?

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**AARON CATLIN:** We try to limit our major changes to the estimate methodology to what we call benchmark estimates and this is not a year that we incorporated any significant changes that I can think of.

**MALE SPEAKER:** Can I try another run at the cost of Part D which I think is a little bit confusing. The rebates were bigger for the states under Medicaid, they're less under Medicare, is there a way to figure out how much more the taxpayers, state, local, all taxpayers are paying for drugs that are being financed under public programs?

**STEPHEN HEFFLER:** I think with this set of estimates that's not really possible and we haven't really done that kind of work, this is really just to report the aggregate levels of spending by servicing consumer sponsor and to try to offer some explanations of those trends, but some of those policy implications are really beyond the scope of our work.

**RICK FOSTER:** To define the other side of that too [inaudible] in this presentation. The beneficiaries signed up for Part D who didn't previously have insurance, they were just going to a drug store and paying out of their own pocket with rebates or the price discounts. And now under Part D they're getting significant rebates and price discounts. So that effect [inaudible] the Medicaid aspect tends to raise the cost of the other aspect to lower the cost. In fact [inaudible].

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**KEVIN FRANEN:** Kevin Franken, with [inaudible]. I thought the introduction of the private sector into Medicare was designed to slow the growth of healthcare spending, and did you report indicate that it's actually increasing how much we spend on healthcare in the US?

**AARON CATLIN:** I mean, in the report we do list that the uses has gone up and Part D, some of that is attributed to Part D. And then there is some increase growth from the rebates, but...

**STEPHEN HEFFLER:** I don't think that we would conclude that it's increased the cost of healthcare or necessarily that it has decreased it either. I think it's difficult to tell once you get all the historical data in what the impact, what it would have looked like in absence of the actual experience. So we won't really have an opinion on whether it's increased it or decreased it. We're essentially at the same growth rate in aggregate that we were in 2005, and that's very close to what our expectations were last year.

**RICK FOSTER:** Yes. Also Kevin, let me just add that [inaudible]. One big picture item is that the source of payment for the prescription drugs is changing [inaudible] as we've shown [inaudible] Part D. Those are [inaudible] the overall cost of prescription drugs in the US has changed very little as a result of Part D and it's even hard to say has it gone up slightly or is it going down slightly.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I think the best answer is just to think of the down cycle, you get a lot more use when we get a better discounts and rebates than before without Part D. Reality is [inaudible] came from Medicaid where we don't get a higher rebate, and fewer enrollees came from elsewhere where we would have gotten a higher rebate. Then I think the reality is probably that it may have gone up slightly rather than having gone down slightly. But the big picture is we never expected it to be very [inaudible], but that still happens in Part D.

**MALE SPEAKER:** Just one small follow up. I was just curious, you said that the rebates negotiated by the states were greater than what had been negotiated by private sector, but you haven't, you haven't been very precise. Is there a way to put any numbers behind that?

**RICK FOSTER:** [Inaudible] is what we've got, the Medicaid rebates of the [inaudible].

**MALE SPEAKER:** Did you say 18-percent?

**MALE SPEAKER:** Medicaid?

**RICK FOSTER:** Yes.

**STEPHEN HEFFLER:** And we don't get it from the [inaudible] from our own data.

**RICK FOSTER:** An independent source. Medicaid across the board for all types of drugs, for a long time is in the 17 or 18-percent range. In the last couple of years it actually went up [inaudible].

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**STEPHEN HEFFLER:** Much higher, yes.

**FEMALE SPEAKER:** Like 20-percent or?

**STEPHEN HEFFLER:** Closer to 30-percent.

**RICK FOSTER:** These are the figures we can get but I don't remember them off the top of my head. For Part D and for other private health insurance plans, the typical across the board [inaudible] percentage is going to be anywhere between 5 and 10-percent, sometimes it might be better than that, but probability is worse. But clearly, it's not the same level as with Medicaid where you have an [inaudible] mandate and rebates are not negotiable but mandated.

**AARON CATLIN:** We can tell you in net that if the rebate levels were the same in 2006 and 2005, prescription drug growth rate would have been around 8-percent, 8.1-percent instead of the 8.5-percent. It's a rough idea of the magnitude we're talking about, that's the net effect of all rebates taken together.

**ROBERT:** And your expectations with [inaudible] the year 2006, given the variables, utilization of prescription drugs to the population and rebate [inaudible]. In other words, your expectations [inaudible]. Have rebates [inaudible] what you expected [inaudible] full utilization of the [inaudible]?

**RICK FOSTER:** I think we did provide that Robert, we don't have the figures off the top of my head. I think it's

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

correct, these rebates, the actual rebates have been higher than we originally assumed [inaudible].

**FEMALE SPEAKER:** I'm sorry, the original, the rebates for Part D were higher than you expected.

**RICK FOSTER:** Yes, the actual rebates in 2006 even though, as we talked about, rebates overall came down somewhat. The Part D rebates compared to our original estimates were programmed [inaudible] I believe are a higher percentage [inaudible] all this afternoon [laughter] you ask the question.

**RICARDO ALONZO SALDIBON:** Yes, getting back to Kevin's question about whether the increase for private plans in Medicare contributed to an increase in overall costs, Ricardo Alonzo Saldibon, LA Times, through your chart growth by service category, it shows hospital went down, doctors went down, nurses went up and you explained that prescription drugs went up because it's more utilization and because the rebates were lower. And then you've got administration and net cost and that went up significantly and you're saying most of that was due to the growth of private plans and Medicare primarily in prescription drugs and also in Medicare Advantage. So why wouldn't the answer to Kevin's question be yes. I mean, it appears that the expanded role of private plans did increase costs.

**STEPHEN HEFFLER:** I think it's difficult to tell from this because you don't know what it would look like if it

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

didn't look like this. [Laughter] I mean it's, this is what, this is showing that there's certain trends across services and there's certain affects of a new program where there are administrative costs that there weren't before and that shifts money around services just like we showed it shifted around sources.

When you put everything together I don't think that we could speak to whether the overall spending would be more or less, would grow more or less than the 6.7-percent that we reported. And so that's how I interpret the question would be, would we have spent more in overall health dollars than what we're reporting, and I don't think we can answer that.

**RICARDO ALONZO SALDIBON:** You're right, it is kind of hard to figure would we have spent more. My question was more like did we spend more? And that one you should be able to answer, not what would have happened under other circumstances or in the absence of but what these numbers show. I mean, when you put it together in the aggregate it's maybe a small increment but you do have that 8.8-percent growth and that, doesn't that suggest what did happen is that the expanded growth of private plans did contribute to an increase in overall healthcare costs?

**STEPHEN HEFFLER:** Well it's certainly contributed to the increase from '05 to '06, but whether it contributed to an increase that would have been greater, would have been less

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

than what happened, if that weren't the case, I don't think we can speak that, I'm not, sorry if I'm not directly answering your question but I'm hearing it as in the absence of what happened here would we have spent more money. That's the only way to tell whether because of it we're spending more than we would have otherwise and we just can't answer that, but I'm-

**MALE SPEAKER:** [Inaudible] one time setup costs that might be happening and [inaudible] net costs that perhaps [inaudible] is that part, is it reasonable [inaudible] to oppose that [inaudible] part of [inaudible] or as opposed to isolating conferencing [inaudible].

**STEPHEN HEFFLER:** Well there are certainly costs with implementing the new program, and if that's part of what shows up in this bar growing faster than it had in prior years. But again whether an aggregate those costs were not offset in other ways, we just can't speak to it.

Can I follow up on some of this, because I'm getting confused. It sounds like what you're saying is we will never be able to use these annual numbers to determine if effectiveness, again, the other direction of any sort of program implementation or reform in either saving money or triggering increases in spending. Because we'll never know what the universe would have looked like without them. Right? One, we'll never be able to use these numbers to tell whether something worked or something added cost.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**MALE SPEAKER:** If we as in us, it means us authors, then the answer is no because that's sort of beyond the reporting of the information. I'm sure others will take these numbers and interpret them and do analysis on them and reach different conclusions but we have not done that analysis.

**MALE SPEAKER:** Perhaps here's another way to do it. You said that the growth was 8.5-percent in prescription drug uses, and then you said had you had the old system of rebates to this states it would have been 8.1-percent. I'd like to know what that is in dollar terms and if you give us that figure could we then say that the new system of Part D costs X \$100 million more than the old state rebate system. First what's the number, the difference between 8.1 and 8.5?

**STEPHEN HEFFLER:** Yes, we can calculate that. I don't have that number off the top of my head. I would caution about the latter statement in concluding that because this was just to give a rough estimate of what the impact of the rebates would have been if they were the same as last year. That's just a hypothetical situation; we don't know what would have happened without Part D to the rebates. It's just trying to give a rough magnitude of the relative decline that rebates that we saw. But pinning the whole thing on the rebate amount increase this much therefore that's how much more, that's only one piece of a much larger puzzle about the whole Part D benefits.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**MALE SPEAKER:** Well if we presume, if there was no Part D, why would we not presume that the states would simply continue to get the rebates that they had always gotten? If Part D had never been put into effect?

**STEPHEN HEFFLER:** Well I think there's issues with all of the, as Rick and Aaron mentioned, there's the other side of it which there are a bunch of people that did not have coverage previously that now have access to rebates that didn't, so you've got to take all the effects into account, you can't just look at one piece of it.

**RICK FOSTER:** Yes, just to follow up on that a little bit, if you look just at the one piece, look at state Medicaid [inaudible] and say, okay, that's a factor [inaudible] is important. What Steve's saying is there are many other factors, let's just take an example, take randomly a 2006 Part D enrollee and you know what's been spent on that person for 2006. Now if that person happens to be someone who let's say had an employer, sorry, prescription drug coverage for 2005 and earlier and now the employer is signed up this person in a Part D plan, maybe not much has changed. The employer got rebates, the employer got discounts, the person had coverage they bought whatever percent of drugs they needed to, and all that right now nothing much has changed. So with or without Part D expenditure wise nothing much has changed for that individual.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Now take a different individual, take one who was covered under Medicaid before, they still have very comprehensive coverage, their use probably hasn't changed and they're still getting the same drugs, they don't get the same very large rebate that Medicaid programs give but they get a pretty decent rebate [inaudible], you still get a pretty good discount, price discount. So that person is then more expensive than it was. Take somebody else who had been uninsured before, they were buying drugs out of their pocket, not because they have coverage but the use is probably gone up. So they're probably getting more drugs than they were before because [inaudible] is better.

At the same time they're not getting the benefit of the retail discount, it's probably 10 or 12-percent, they're probably getting the benefit of the rebate and that's [inaudible] related the 5 or 10-percent for [inaudible]. But overall that person could be more expensive to the system because of the higher use or it could be cheaper because the new rebates and discounts more than offset the higher expenses.

So that's why it's complicated to answer this. Now one more example if you can stand it, which is to superimpose on all of you [inaudible], the private Part D plans, much like all the other private drug insurance plans out there, are further pushing the use of generic drugs to a variety of [inaudible]. So on top of this, one or more of these people switched from

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

what had been brand drug usage to generic drug usage that affects the overall balance of health [inaudible]. Now sooner or later somebody's going to do a dynamite study and figure this out. [Laughter] But we haven't done it yet.

**MALE SPEAKER:** Excuse me, what you said before is the after rebate on Medicaid. You said 5 to 10-percent of the private, what did you say under the Part D?

**RICK FOSTER:** What I'm remembering and what we're going to try and confirm for you all this afternoon, what I'm remembering is the 18-percent level for a long time, and then it went up over the last couple of years by [inaudible]. But I don't remember [inaudible] July.

**MALE SPEAKER:** You have that -

**FEMALE SPEAKER:** Yes, it's got 30-percent.

**MALE SPEAKER:** About 30-percent.

**MALE SPEAKER:** It went up because of state laws or because of more effective negotiation types in the end?

**RICK FOSTER:** All of the above.

**MALE SPEAKER:** It went up to 30-percent?

**STEPHEN HEFFLER:** And that's the Medicaid rebate is about 30-percent.

**RICK FOSTER:** Mary Carol, is that across the board as you off all drug expenditures?

**MARY CAROL:** Yes, 30-percent of those.

**RICK FOSTER:** Okay, not just direct?

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**MARY CAROL:** Right.

**RICK FOSTER:** I just wanted to make sure.

**FEMALE SPEAKER:** And that varies from state to state?

**MARY CAROL:** That's the national total.

**FEMALE SPEAKER:** That's the national average?

**LISA MARCUS:** Lisa Marcus with [inaudible]. Just to go back to the administration and net cost spending and [inaudible] service category. I'm just wondering when, what part of this is due to the new administrative costs that's on the public side and private side for Medicare Advantage, can you break it down any further? Is there a way also to compare what the administrative costs and the Medicare fee for service versus Medicare Advantage?

**MALE SPEAKER:** Yes.

**CATHY COWAN:** Do you have that?

**FEMALE SPEAKER:** Yes. Per service and Medicare Advantage, those contribute on this equal the proportions to total Medicare administration. So the increase was both from fee for service and Medicare Advantage.

**MALE SPEAKER:** So there's not an extra administrative cost for Medicare Advantage or in care flexibility?

**FEMALE SPEAKER:** No, no. All total Medicare administration it's [inaudible] covers fee for service and Medicare Advantage.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**MALE SPEAKER:** What has happened is that we get a lot more people [inaudible]?

**FEMALE SPEAKER:** Yes.

**MALE SPEAKER:** So those [inaudible] but not as [inaudible].

**FEMALE SPEAKER:** Yes.

**AARON CATLIN:** And as a proportion, as a proportion the Medicare administrative costs and fee for service is much smaller proportion than it is under the Medicare Advantage.

**FEMALE SPEAKER:** Wait, say that again.

**AARON CATLIN:** The proportion of total spending that administrative costs represent is much smaller than fee for service than it is for Medicare Advantage.

**MALE SPEAKER:** Which implies that the administrative costs – such as more expensive for MA than it is for [inaudible] fee for service [inaudible].

**AARON CATLIN:** I think it is fair to say that on a per person basis.

**MALE SPEAKER:** [Inaudible].

**AARON CATLIN:** Yes, a per person basis.

**FEMALE SPEAKER:** For per person it's the same?

**AARON CATLIN:** No.

**FEMALE SPEAKER:** Per person it's?

**AARON CATLIN:** Per person it's higher for Medicare Advantage than it is fee for services.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**FEMALE SPEAKER:** Is that just for what Medicare pays or is this between the total private plans and [inaudible]?

**AARON CATLIN:** This is Medicare outweighs whether they're through a fee for service benefit or a managed care benefit.

**MALE SPEAKER:** So the administrative cost is higher than [inaudible] fee for service.

**FEMALE SPEAKER:** Do you have the total number for the total spending on a Medicare Advantage beneficiary versus a fee for service expenditure? Not just administrative costs but total spending on [inaudible]?

**AARON CATLIN:** Per person?

**FEMALE SPEAKER:** Per person, yes.

**AARON CATLIN:** Yes. We have that.

**RICK FOSTER:** Keep in mind that it's a bit of an apples to orange comparison because the [inaudible] Medicare Advantage where earlier areas where the costs were quite a bit higher than [inaudible]. So, we can give you the figures but it won't prove that why is X percent bigger than the other strictly because it's MA versus fee for services [inaudible].

**MALE SPEAKER:** I think I many have, I'm confused. So an individual beneficiary in Medicare Advantage costs Medicare more than if that person was in traditional fee for service, in terms of administrative costs? I mean, that's why they get 112-percent, right? Wasn't that the whole problem?

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**MALE SPEAKER:** Right, yes, that's—

**MALE SPEAKER:** [Inaudible].

**MALE SPEAKER:** Yes, that's—

**RICK FOSTER:** You guys are asking great questions, but this is a little complicated. [Laughter]. If you want we'll explain it. [Laughter]. But it's a little complicated.

Okay, [inaudible] percent [inaudible] measured and our figures are [inaudible]. That's generous; it's almost entirely [inaudible] the fact the way that payments to the plans work. There are benchmarks in the wall. And they are typically set higher than prevailing fee for services.

In other words, fee for service is the lowest of the benchmarks [inaudible] are often higher. Now a claim comes in and bids and says [inaudible] Medicare Advantage, okay. For the sake of argument suppose that their actual average cost is the same as fee for service. You have a benchmark that's 108-percent say [inaudible], 108-percent from the fee for service level, the plan gets 100, the plan gets paid their 100 plus three-fourths of a difference, so they get 116-percent.

So clearly we're paying that plan more than we would have paid somebody in fee for service. Now, of course, the beneficiary gets something out of that because they have to take that six and three-fourths of a difference and buy extra coverage, extra benefits or sharing lower premiums, whatever. By law they have to provide all those services. No, all that's

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

one side of the picture, you with me so far? Let's just to the other side of the picture.

Let's hit the plan costs for this illustration about the same as fee for service. Now do the plans cost more than fee for service, do they cost less than fee for service? Well, plan by plan it can be either one. A plan has a strike against it typically because they don't have the same economy as the state for administrative costs that Medicare does in general. The typical plan in administrative costs is putting non-profits, might be say in the 8 or 9-percent range. Medicare fee for service for the giant economy of scale is only a couple percent. So that's a strike against the plan.

On the other hand maybe the plan can negotiate payments with its own providers, hospitals, doctors, et cetera, that are less than Medicare fee for service payments. That used to be quite common, it's not very common in these places, but it used to be quite common.

Also the plans typically can manage care to some degree. They can keep an eye on utilization to make sure its not frivolous or inappropriate. The best most cost effective services are following, so they can get savings out of that whereas the Medicare fee for service don't do that. So whether that plan ends up being more expensive than fee for service level does the add in cost to profit more or less expensive because of better negotiated prices and utilization measures,

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

that's varies from plan to plan [inaudible]. Okay, that was like the whole semesters worth. [Laughter].

**MALE SPEAKER:** Can we get the figures too though? If you can think of any [inaudible].

**FEMALE SPEAKER:** Do you want me to give you the [inaudible]-

**MALE SPEAKER:** Fee for services for care compared to-

**FEMALE SPEAKER:** Per enrollee fee for service total for 2006 is \$9,538 per fee for service enrollee. For Medicare Advantage enrollee total spending was \$10,133.

**FEMALE SPEAKER:** That's Medicare spending?

**FEMALE SPEAKER:** That's Medicare Advantage spending, \$10,133.

**FEMALE SPEAKER:** And those are government only? That doesn't include any out of pocket or any of that other stuff, is that right?

**FEMALE SPEAKER:** Those are, correct, out of pocket-

**FEMALE SPEAKER:** Doesn't include out of pocket.

**FEMALE SPEAKER:** It does not, is not.

**FEMALE SPEAKER:** Is not, okay.

**FEMALE SPEAKER:** Premiums, that [inaudible].

**MALE SPEAKER:** Yes, Medicare payments on the average handle all these [inaudible] Medicare services.

**FEMALE SPEAKER:** Could you repeat the first number?

**FEMALE SPEAKER:** The first number was \$9,538.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**FEMALE SPEAKER:** So this isn't just the administrative spending, this is—

**FEMALE SPEAKER:** Oh no, this is total services and [inaudible]—

**FEMALE SPEAKER:** By Medicare.

**FEMALE SPEAKER:** —fee for services and administration.

**FEMALE SPEAKER:** Can I jump back to a slightly different question? We were talking about the plan of administrative and net costs, and it's gone up, do you forecast what's going to have to go forward given the projections on whether this trend will continue along the same lines?

**AARON CATLIN:** We have an annual set of projections that we release each February, and the expectation is that we will have an updated set with information from 2007 through 2017 available at the end of February.

**MALE SPEAKER:** [Inaudible]. [Laughter].

**MALE SPEAKER:** Probably do another one of these.

**MALE SPEAKER:** Yes, ask simpler questions then.

[Laughter].

**DOUG TRAP:** Changing topics a little bit too, Doug Trap, American Medical News, as far as physicians and clinical services go, you mentioned that the fact of 3-percent or .2-percent update on private health plans payment, is that a demonstrated year to year effect? Is that a commonly accepted way of, not just accepted but just a way of influence of prices

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

from year to year for physicians? Or is this just like a one year thing?

**CATHY COWAN:** Well, the growth in prices was unusually low, I would guess, in 2006 as compared to earlier years. So it's hard to say whether it's just a one time effect from the Medicare because Medicare updates are generally in that type of range. So it's hard to tell right now what was going on with that, that update. But 2006 was, I can say, a lot lower than other previous years and what actually drove that, as I said, it looked like it was broad based so it was again, it was not only public payers but private payers.

**MALE SPEAKER:** You think the opposite would be true if there was a significant update for Medicare, that there would be a press jump on private plans as well for physicians?

**CATHY COWAN:** You'd have to look at the prices, you'd have to look at the individual services to see what kind of went on with that and we just don't have the detail at that level to kind of look at that.

**MALE SPEAKER:** So that's the sort of, this sort of aberrant update, aberrantly low update is the main; it may be kind of an aberrantly low year in terms of price growth because of the [inaudible].

**CATHY COWAN:** Yes, as I say, it was kind of very low. I mean, it was only like 1.8-percent growth whereas generally

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

it's been around like 3-percent price growth for physicians.

It's right then, so.

**MALE SPEAKER:** Is it fair to say that there is some historical data partial year data available for '07?

**CATHY COWAN:** Correct.

**MALE SPEAKER:** That's in and there's a year where there's a low Medicare update but it looks like the aggregate prices are actually back more in their normal...

**CATHY COWAN:** Yes, if you look at...

**MALE SPEAKER:** -'06 does look a little average.

**MALE SPEAKER:** Very good question, thanks. Let me write that down.

**CATHY COWAN:** Correct, yes. If we look at the 2007 data we're seeing that the growth of prices for physician services is going back to previous. It's inching back up to that previous level.

**MALE SPEAKER:** So figure in the talks about GDP, or I'm sorry, the health spending growth are facing GDP by only 0.6-percent points, can you put that in context? I mean, how does that compare with other years rather to?

**AARON CATLIN:** Yes, if we go back to the slide with the, and take a look at it, you can see, look at your printed out slides, that's the slide in the set where we had the MAT growth and the GDP growth, and this is one thing that we had written about in last years article, was sort of the

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

interaction of GDP and NHE and the sessions and recessions and that's why we've marked the recessionary periods here. And health spending, you guys are all on the [inaudible] page?

**MALE SPEAKER:** Yes, it has the growth-

**AARON CATLIN:** Yes, it has the trend and NHE and then GDP. So you can we've marked the recessionary periods there and during recessions health spending actually is higher in the last three recessions that are here, is much higher than GDP growth and there's a lagged impact of these recessionary forces on health spending so you don't see the slowing until several years later. It takes time for the recessionary forces to filter through those infrastructures in the health sector.

So this convergence that we see, and I guess that's getting to the question that you're asking, is the difference between the GDP growth rate, in nominal terms is important, nominal, versus the NHE's, is fairly consistent with convergence that we've seen in previous periods that are post-recessionary. And you can see the previous two years on here were much closer and then we started to diverge just slightly.

**RICK FOSTER:** I would add to that that if you look at the very long run history of these two series, the health spending has grown about 2.5 percentage points or so faster on average per year than economic growth. So in that context, point six historically is relatively similar growth rate as compared to a very long run average.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**MALE SPEAKER:** It's a lot lower isn't it? As well?  
Two point five versus 0.6.

**RICK FOSTER:** Yes, it's a, the closer they are growing more similarly than they have, in this year than they have over the long run history. The long run history they've been different by about 2.5-percent...

**MALE SPEAKER:** That's very unusual, right?

**RICK FOSTER:** That they would be this close?

**MALE SPEAKER:** Yes.

**RICK FOSTER:** I think as Aaron said, it's actually not, if you look at the last three post-recessionary periods, it's not unusual that they would converge a few years after, and then...

**MALE SPEAKER:** So is there any reason to think, so there, they're not likely to stay similar? Is that, you're suggesting based on-

**RICK FOSTER:** Last year in the projections we released in February, the expectation was that they would, that health spending would continue to grow faster than GDP over the projection period, ultimately reaching I think a little less than 20-percent GDP and we're at 16-percent now.

**MALE SPEAKER:** Can I ask an out of pocket question? So you have two figures with prescription and without prescription, by 5.2-percent down to 3.8-percent is an effective increase by, is an effective increase Part D

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

benefits, right? People have more benefits, they're spending less of their money as a percentage total healthcare spending? I'm on the slide here, the, I just wanted to try and interpret that.

**AARON CATLIN:** Can you say that again to make sure.

**MALE SPEAKER:** Yes. Of 5.2-percent, with RX, 5.2-percent down to 3.8-percent. I guess people are spending less of their own money as a percentage of overall healthcare spending because they have more Part D benefits. So without our X figure, which is a slight acceleration, I mean, Part D does exist. We have it so, what's the purpose of the second number, what does it really mean? Without RX, is it just their out of pocket spending on all other health services just not prescription?

**MALE SPEAKER:** Right.

**MALE SPEAKER:** So then what is the, what is then the aggregate since most, since people have both prescription and non-prescription, one is slowed the other has accelerated? What's the total?

**MALE SPEAKER:** The total is the [inaudible].

**MALE SPEAKER:** Is the risk.

**MALE SPEAKER:** Right.

**AARON CATLIN:** [Inaudible].

**MALE SPEAKER:** Right. Got it, thank you.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**LISA MARKETT:** Hi, Lisa Markett with [inaudible]. On the price growth with prescription drugs you said it was 3.5-percent, which was the same as previous year, but how does that compare with overall inflation in 2006?

**AARON CATLIN:** Let's see, I think we have the article with growth and GDP [inaudible]. Okay, the GDP and plus the price deflator grew 3.2-percent in '06 and in '05.

**FEMALE SPEAKER:** That's on exhibit two? In the article?

**AARON CATLIN:** Page 16 in the article.

**FEMALE SPEAKER:** Page 16? Thank you.

**MALE SPEAKER:** Is there any, and there shouldn't be, between the increased level, are the increased growth prescription drugs spending and the decreased growth in hospital spending, any way of knowing there's some kind of an effect there?

**AARON CATLIN:** That's beyond the scope; we haven't looked at any interaction like that.

**STEPHEN HEFFLER:** We get that question a lot and I think it's one that there are possibilities but there hasn't, we haven't internally done the analysis to determine if that's, that there's actually a direct relationship there. There are a lot of other studies that people have done outside that take both sides of that issue, but we have not come down and

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

included that. We have done a little bit of analysis internally on Medicare, I think that's [inaudible].

**RICK FOSTER:** We have started looking at that and it's also to look at it for Medicare because that's where we're heading in the direction that we recommended that there's a big picture [inaudible] drug coverage didn't change across the board. So far we haven't been able to determine any of the – look at the ambitions for Medicare beneficiaries, the hospitals use by type of admission. There were several categories that went down quite a bit and others that went up quite a bit there are a bunch of [inaudible]. Over time you do, and this is the hard part, is to figure out that once they're written down are these the kinds of conditions for a hospitalization can't be presented by having access to the right of prescription drugs. A fact that [inaudible].

**MALE SPEAKER:** I think the chart said there was an absolute decline in the Medicare inpatient hospital admissions. I think [inaudible] Medicaid [inaudible].

**MALE SPEAKER:** I don't think we have anything.

**MALE SPEAKER:** Yes.

**MALE SPEAKER:** You don't have data on the Medicaid and patient admissions?

**MALE SPEAKER:** So there's a conference call this afternoon, is that right?

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**MALE SPEAKER:** Yes, there's a 2:00 call, Don, they're asking about the 2:00 call?

**DON McCLOUD:** Yes, [inaudible] this morning [inaudible] 800-619-6567 ask for news brief.

**MALE SPEAKER:** News what?

**DON McCLOUD:** News brief. [Inaudible] [Laughter].

**FEMALE SPEAKER:** That's like the password?

**DON McCLOUD:** I'll be the call leader, I'm Don McCloud.

**MALE SPEAKER:** I'm sorry, what time is that again?

**DON McCLOUD:** Two o'clock.

**MALE SPEAKER:** Thank you.

**MALE SPEAKER:** [Inaudible] who will be on that?

**DON McCLOUD:** Same people that are sitting here.

**FEMALE SPEAKER:** So you have all of the answers to all of our questions? [Laughter].

**DON McCLOUD:** [Inaudible] or what they didn't have.

**MALE SPEAKER:** Let me point out that [inaudible] article in addition to the journal following this [inaudible] that this is quite [inaudible]. Some of the objection issues [inaudible].

**MALE SPEAKER:** So, that was out when you came in, that was out on the table if anybody didn't get it when they came in grab it on your way out the door. I think we're done, again [inaudible] for the people that came in late, the embargo for all of this information is 12:01 AM tomorrow [inaudible]. If

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

people have additional questions [inaudible] the flow.

[Inaudible]. Thank you all for coming then.

[END RECORDING].