

**“Health 101: Prepare yourself for the Debate”
Questions and Answers
Friday, February 21, 2003**

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ED HOWARD: Thank you. Let me encourage you to use these microphones. We have enough written questions on the cards that I can't guarantee that we're going to get to them all before the end of the period. So if you want to absolutely be sure that your question gets asked, take a walk to the mic. Having said that, here is a card. Please talk about the operations of the carriers and the fiscal intermediaries. What do they do? What are their incentives? Are there policy issues that are raised by that topic? Do you want to try that, Julian?

JULIAN PETTENGILL: Medicare uses intermediaries to deal with facility providers, as I pointed out, and carriers to run its administrative claims processing operations and professional relations management. The carriers also handle inquiries from beneficiaries and from doctors and other practitioners about Medicare's policy. They contract with Medicare on a fixed budget basis. There used to be very large numbers of them. We used to have, I think, 72 intermediaries, and that's now to about (unintelligible). And similarly, the carrier population has declined. Now, the original notion of intermediaries and carriers was that the medical community, both doctors and hospitals, did not want to have to deal directly with the Medicare program, with bureaucrats in Washington. They wanted to deal with somebody local. And the Congress enacted this provision for intermediaries and carriers

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to (unintelligible) the administrative operations process some claims and professional relationships between Medicare and the providers. Over the course of time, that's changed a lot. One issue perennially is how much money is made available to the intermediaries and the carriers to carry out, in effect, their business functions, which the carriers and intermediaries always saying there's not enough, and with (unintelligible) saying it's too much, there's a constant tension there. In addition to that, Medicare has added other administrative entities for quality review activities, the quality improvement organizations now, which used to be called professional review organizations. They're just outside entities that contract with Medicare to monitor changes in quality and in practice of furnishing care. They're testing the limits of the (unintelligible) really.

ED HOWARD: I think that's a very good response. Actually, this gentleman was here also. So, do you want to start.

MALE VOICE: (unintelligible) with Senator Pryor's office, and I've got a quick question. On the chart that Ms. Neuman had, 13% of Medicare expenditures, roughly, went to Medicare Plus Choice plan. Does that roughly correspond with the percent of people in the plan, and historically has that been about the same?

TRICIA NEUMAN: Yes is the answer. It does roughly

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correspond. When higher numbers were involved, the figure grew a little bit. So that's about right. It's close to right.

ED HOWARD: Thank you. It's very straightforward.

Yes, sir? Would you identify yourself?

MALE VOICE: Thank you. I'm Edward Gowan with Editorial Services. I have two questions for Tricia Neuman on figure 7 and 8. With respect to figure 7, does that slide correlate well with advancing age? And on figure 8, I wonder whether you can give us some breakdown on the change between 2000 and 2003, if you can just aggregate the causes having to do with the number of beneficiaries, number of prescriptions, price changes.

ED HOWARD: Let me just interject here for those of you who don't have this in front of you, that figure 7, the first part of the question, is about income correlation, has to do with the distribution of expenditures on drugs of people who are Medicare beneficiaries. And the figure 8 has to do with the growth, the out of pocket spending on drugs (unintelligible) over the last few years.

EDWARD GOWAN: Let me just clarify the first question. I may not have made it clear. I'm wondering, as we look at these several bars, whether, if we knew something about the ages of these beneficiaries, would we see that it is increasing as we move into the higher outlay branches?

ED HOWARD: Do we know anything about that, Tricia?

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TRICIA NEUMAN: Well, this is a one-year look at spending, and these numbers, for both of the figures that you're talking about, are based on estimates from the Congressional Budget Office. And the Congressional Budget Office, in the case of the first set of figures, which is that drug spending take into account lots of different factors, age being one of them. It's not quite advancing age because it's just for one year, so it's a look at the age of the population in 2003, as well as other factors. And then for all the people on Medicare, it leads together lots of pieces of information, including what insurance they have; what are the prices of prescriptions; how many prescriptions do people fill, based on their health conditions, their age, and other factors. So, age is a part of many different factors that go into CBO estimates, and that's also true with the distribution. In terms of what effects the growth and out of pocket spending, you're absolutely right, it's a combination of factors: price, quantity, and other considerations. Again, these numbers are derived from sort of underlying assumptions that come from the Congressional Budget Office, that was analyzed by actuarial research corporations, and they pull together a lot of factors, so it's not really possible to tease apart the individual contributions of price, quantity and other factors.

ED HOWARD: Let me remind those of you who are listening and watching from outside Washington, that we do

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solicit your questions as well, and that number for Congressional staff, is on this sheet somewhere. It's 202-789-230, if you'd like to submit a question. If you want to send an email, send it to frontdesk@allhealth.org, and we'll try to get to it as quickly as we can. Here is such a question submitted from outside town, by somebody in a Congressional office. Could someone talk about Medicare beneficiaries who are veterans, going to the VA for prescription drugs and other services, and the burden that this is putting on the VA budget, either qualitatively or quantitatively.

DIANE ROWLAND: Well, clearly, anyone who qualifies for veterans benefits, and is on Medicare and doesn't have a supplementary policy, it's tethering prescription drugs with the (unintelligible) well served by trying to attain those drugs through the VA. The VA actually has a very competitive pricing policy, so it's able to purchase and dispense drugs at a relatively efficient cost. But, obviously, the more that people turn to get prescription drug coverage through the VA, the VA is, in effect, subsidizing some of what others believe should be Medicare's own burden.

ED HOWARD: Here's a question for Julian. You mentioned that payment systems have to be monitored because they can't stand alone. Could you elaborate a little bit. Is the only monitoring through payment formulas, or is there some (unintelligible) drawn device that's used?

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JULIAN PETTENGILL: No. A variety of events occur all the time, and frequently have throughout the history of the program, where you see particular kinds of behavior from providers, and it ranges from offering perhaps more services than beneficiaries need to outright fraud in coding records. That's part of the program integrity work that is needed to accompany any payment system. A lot of that is done using programs that are inside CMS that also involve the operations of the contractors who audit providers' cost reports, monitor the claims for medical necessity, and that sort of thing. And then, in addition to that, as I mentioned earlier, the Congress has gone back as far as the early '80s, created quality review organizations that were intended to track what providers were doing. Whenever you implement a payment system that sets fixed rates--for example, the hospital inpatient system, the fear that many people had at the time was that providers would start discharging patients as quickly as possible, some of them prematurely. So Congress created the professional review organizations and charged them with the task of monitoring what was happening to patients, and the Office of the Inspector General also monitored what was happening, whether patients were being discharged quicker and sicker, as the term was. And there's also concern about closures of facilities and areas where, presumably, it's hard to attract doctors to provide services because the payment rates might be too low. So people

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are always concerned about monitoring access to care, and it's very difficult to do because the places where you have a problem are likely to be strictly local, and you have to have a monitoring system that is able to pick that up in, say, some portion of rural North Dakota, and it's very expensive to do that. But you do need systems to monitor what providers are doing, (unintelligible) the quality of care and access to care. It's always important.

ED HOWARD: Thank you. Yes?

FEMALE VOICE: I'm with (unintelligible). Would you talk a bit, please, about the shrinkage of the Medicare Plus Choice program, why it happened, and what's the implication for what the lessons might be for some of the Medicare reform proposals that are being talked about now?

ED HOWARD: Tricia, do you want try to take a first crack at that?

TRICIA NEUMAN: I'll give it a start. Let's start with the growth first because that's sort of gives us a running start to look at the shrinkage. The program's moved very rapidly, in part because health plans perceive this to be a pretty good line of business to go into. What you saw in the mid-1990s were many plans coming into the Medicare program because, at the time—and I don't mean this in any way negatively about the plans—Medicare was overpaying plans, and there are numerous government reports, GAO and others, that

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have shown Medicare overpayments to plans. So it was a very attractive market. It was also very attractive to beneficiaries because plans were coming in, because they were being paid more than their costs, they were giving back benefits to enrollees, which were almost too good to be true. If you saw ads in 1997-98, you'd see people in the ads saying, this is too good to be true. A buck's a buck. I can't not sign up for this program. Because there were no premiums, there were generous drug benefits. It was all a fairly great thing from a beneficiary point of view. But in 1997, the Balanced Budget Act took a good hard look at the Medicare HMOs and really started to modify the way the program was paying Medicare HMOs. And, as you probably heard from the managed care industry, it has become tougher for plans to stay in Medicare, provide services to this population, and still make a profit, because in the end, they're businesses and that's part of what they need to do. So over time, while many plans have hung in there, some simply haven't been able to, and those who have, have cut back in benefits, and that's a little bit of a vicious cycle because then the programs themselves become less attractive to seniors and they get lower enrollment, and then that, in turn, makes it difficult to run a business if you don't have enough people signing up. So, in terms of a lesson, I think it goes sort of back to what I was saying earlier about a triple balancing act. Finding a way for the government to

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set fair payments to plans without overpaying plans is a difficult challenge, and if times are tough and Congress needs to look for ways to slow the growth in Medicare spending and, in the end, has to start to clamp down on payments to private plans, then it's reasonable to assume in the future that experiences in the past will repeat themselves, and plans may decide that they can't continue to operate with Medicare under tighter fiscal circumstances. Unless anybody wants to add.

DIANE ROWLAND: We have another question here that kind of picks up on that point as well, saying, what's the advantage of Medicare Plus Choice compared to regular Medicare for the beneficiaries? Do they have more or fewer health care provider options? And I think that Tricia's point is that the stability of the fee for service Medicare program--it's been there since 1965 and it remains there--is one of its most popular features among the Medicare beneficiaries. They know that Medicare may not cover prescription drugs, but it will cover their hospital bills and it will cover their physician bills, and it will allow them a free choice of providers. So in the traditional Medicare program, the choice is of providers. In the Medicare Plus Choice program, the choice is of plans, and some of those plans are much more restrictive in terms of what providers can be seen, but the advantage of those plans has been, but it is eroding, their ability to offer a wider benefit coverage in terms of prescription drugs and some of the other kinds of

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things that we talked about as now declining. Lower premiums for getting into the plan. Now, more of these plans require premiums. More of these plans are putting caps on the drug benefits or limiting the drug benefits. So, the attractiveness of the Medicare Plus Choice plan was really in the benefit and not in the choice of providers. The attractiveness of the traditional fee for service program is assurance that it's going to be there and it's not going to withdraw from the program in a year, and (unintelligible) you can have choice of providers.

ED HOWARD: I just add one point, if I can, and I'll just put it on the table, and people who really know about it can elaborate if it's worth it, and that is the question of variation in payments geographically. Tricia alluded to that by saying, in some areas the HMOs had a higher payment level. There's a stunning level in the difference in the payments that HMOs get in one place versus another. Just ask Senator Grassley, for example, or Senator Baucus about what the rates are in Montana and Iowa compared to what they are in Dade County, Florida. And that makes it a lot easier to offer a rich benefit package in some of those high payment areas. And the real question is how you get past that. Maybe Julian has something to say about how the variations in payments in the regular Medicare program shape up and therefore influence the payments in a managed care setting.

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JULIAN PETTENGILL: Well, I guess at some level, the question for Medicare Plus Choice is what is the expected cost pre capita to furnish Medicare's covered services in different parts of the country. There has always been some linkage between the Medicare Plus Choice payment rate, just a per capita monthly payment rate, and the historical level of spending for a beneficiary under the fee for service program. Part of the variability is accounted for by differences in the population of beneficiaries and in their whole status. Part of it is accounted for by differences in input prices, salaries, wages, events, and so forth which vary tremendously across the country. But a part of it is practice pattern differences that exist from market to market. And one of the questions that the commission has wrestled with is whether you can successfully have rates in Medicare Plus Choice that differ substantially from the per capita rates in effect under the fee for service program in the same market. They have come to the conclusion that you can't sustain that in (unintelligible). And you might boil that down to a phrase which says essentially, look, you can't fight the marketplace. If the market in an area, with its practice patterns and its market rates of wages and rents and so forth, dictates a certain level of spending, you can't pay Medicare Plus Choice plans less, and conversely, you can't pay them a whole lot more than you would be spending per capita under future service, and have both programs be

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(unintelligible). The other issue that is really important here is that Medicare Plus Choice plans don't exist in many parts of the country, and part of the reason they don't exist is because, particularly in many rural areas, even though available rates are well above what they'd be paid under future service per capita, the problem is that there aren't enough people. To run an insurance program successfully, you have to enroll people and lots of them, because you depend on averaging to make money. If you don't have much of a population, and it's a declining and aging population, it's not going to be a good business decision to locate there, and that's part of the problem that's creating this regional disparity.

ED HOWARD: Thank you. Let's go back to the microphones. Let me remind you, by the way, that we would like to have those evaluation forms filled out before you leave, as we get through the question period. Thanks very much.

MALE VOICE: Alan Blacks (misspelled?) with Senator Biden. Given that Medicare prescription drugs is going to be another hot topic this year, I wonder if I could ask Dr. Neuman if we could go back to figure 8, which shows the out of pocket prescription drug expenditures. These show average or mean expenditures, which, to my recollection, are enormously skewed by the high values. I would like to ask you, do you have any data, like for 2004, on what the median or percentage distribution is of the out of pocket expenditures, number one?

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And number two, how would you go about crafting a politically acceptable prescription drug plan if a huge percentage of seniors already have out of pocket expenses that are below the annual premium to deductibles for your proposed prescription drug plan?

TRICIA NEUMAN: Let's start with the first question. We do actually have distributions, and you're right, these are averages, which sort of obscure various--this is the high and then there's the low end. On the high end, there are about 5% beneficiaries with out of pocket spending which is over \$4,000, so it's a pretty small number. Again, it's a small share of the total which have a lot of out of pocket spending, but you also have larger numbers at the bottom. I mean, I think that speaks to your next question. There were 16% of beneficiaries with no out of pocket spending--again, this is in 2003--and close to 40% that have less than \$250 in out of pocket spending. So you're right, there is a political challenge. This is also true in any kind of an insurance scheme because there are always going to be people who have very little spending, and there are going to be a small number of people with very high spending, because the concept of insurance is pooling people with low and high spending; so it's always true that people who are fortunate enough to be healthy that year and have no expenditures will pay something in premiums and maybe not collect that year. But in the end, you're building a

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system so that when they do become sick, and they do use their services, that services be in place, and the healthy will be helping to offset the costs of the sick.

ED HOWARD: And you can sort of infer a medium of some—chart 7 is the distribution for 2003. My training in law doesn't qualify me to assert this, but I think the 18% bar between 1,000 and 2,000 represents something of a midpoint.

FEMALE VOICE: (unintelligible)

ED HOWARD: That's for certain. Fair enough. I think you were there first.

FEMALE VOICE: I'm a student from George Washington University, (unintelligible). My question refers to figure 10 of Ms. Neuman's slides, referring to the hospital insurance trust fund. It seems as if we're in danger of depleting the fund around year 2029, and my question refers to Part B of Medicare. Where do we stand as far as the (unintelligible) revenues for Part B?

TRICIA NEUMAN: I'm glad you pointed out this slide because actually we had modified it for the second page—it was actually 2030, and that's Part A, the hospital trust fund. But as Diane's slide earlier showed, that Part B is funded separately. Part B is funded by a combination of premiums and general revenues, so it's not quite the same kind of trust fund that you see here, which has a dedicated share of payments that come from payroll taxes paid by workers and employers—that's

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Part A. Part B is from the combination of funds that come in over time, from people on Medicare and from general revenues, and people on Medicare are paying about a quarter of the total of Part B expenditures.

ED HOWARD: So, in effect, it cannot be exhausted because it has a call on general revenues for however much it needs to pay all the bills in Part B. Am I right?

TRICIA NEUMAN: That's right.

ED HOWARD: That doesn't mean that there aren't a lot of people in Congress who are worried about Part B expenditures. Yes?

FEMALE VOICE: Kim Glaun (misspelled?) at the Medicare Rights Center. In terms of setting payment rates, how does Medicare compare to private insurance in making sure that the payments to providers are accurate, that is, not overpaying and not underpaying?

JULIAN PETTENGILL: That's a tough one because it's hard to know whether they're too high or too low at any point in time, and that's just as true for Medicare as it is for private payers. We actually, at the Commission, spend a lot of time puzzling about that annually, and we think about how much of an update to recommend for the payment rates in each setting. A couple of years ago, we put together a chapter of one of our March reports that basically raised the question, okay, you're setting payment rates and you know that various

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kinds of things can go wrong, how would you know when they're going wrong, and how would you relate what you see back to payment? And from that we developed an update framework where we try to analyze changes in the volume of care, changes in entry and exit of providers from a market--closures of hospitals, for example, or disappearance of home health agencies from a local area--and changes in the quality of care, changes in the nature of the products. One of the things that's been happening in hospitals for some years is that more and more patients are being discharged to post-acute care. What does that mean? Does that mean the payment rates are too high or too low or what? So we try to figure all of that out. Knowing what private payers do is really hard because a lot of them on proposition payment, many of them use something like the Medicare fee scheduled, and they update it differently for hospital payment--many of them negotiate rates. And remember, Medicare is big vis-à-vis providers, and most insurance companies are not. They have very little leverage, so they negotiate rates with providers. But are those rates too high or too low? Well, if they're negotiated rates, almost by definition, they can't be either too high or too low. They are what they are. In short, it's a really difficult question to answer, and maybe the main advantage we have in dealing with this is that we get to deal with it sort of by success of approximation. We set an update this year. We go back and

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monitor what happened and what's happening when we get to set an update the next year, taking into account what we learned in each period, as we get new information. The biggest stumbling block of all is that the best information we have about what's going on is almost always at least two years old. So it's really hard to know where things are right at this moment, and we do the best we can to pay attention to trends and decide how much of an update providers need to continue to provide high quality care.

ED HOWARD: (unintelligible) I'm sorry, go ahead.

DIANE ROWLAND: I think, one of the things we often have to consider is that Medicare is up there with its payment rates, inevitably knows what they are, but it's very difficult to find out what any individual health insurance plan, or especially now that we've moved toward more and more managed care, what the managed care plans are negotiating with different physician groups, and the same group of physicians may be (unintelligible) three or four different payment levels, based on how many contracts they have with different managed care plans. So, when we try to compare anything to the private sector, we really have an information gap that we don't have when we look at the Medicare program.

JULIAN PETTENGILL: And you might add to that, that when you ask private payers what they pay and how they figure out what they pay, for the most part they don't want to tell

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you because they consider it like a trade secret, honestly.

MALE VOICE: Hello, I'm Peter Bustinoff ((misspelled?) from the Netherlands Embassy, the health counselor, and I have a question to Mr. Pettengill. In the Netherlands, we are now discussing also the introduction of diagnosed related groups, and I recently was informed that we started off by 16,000 and now back to 600, so I guess it will go up a little bit again too. So, my question is to you, on the basis of our experiences here, and given the fact that your citizens won't have very much different diseases than we have in the Netherlands, I mean, what would be your optimum number of diagnosis related groups or could you say something about that?

JULIAN PETTENGILL: You know, it's funny, there used to be serious arguments here about whether 470 DRGs was too many or too few, and part of the problem you face is that each category is supposed to represent a homogenous set of patients in the sense of they have the same clinical problem and they're likely to require a similar amount of resources for treatment. The problem is that, if you look at the distribution of people by diagnosis, what you'll find out is that you've got a huge concentration in a relatively small number of diagnoses, and then lots and lots and lots of people with relatively rare diagnoses. So, you can have 510 DRGs, maybe the top 100 account for 70% of the patients, and the remaining 410 account for only 30%, and by the time you get past the first 150,

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you're down to very small numbers. From the payment perspective, that doesn't matter very much because it's all occurring inside the computer anyway, right? I mean, administering claims, the computer looks and says, well, which DRG does this go in and what payment rate is attached? But, from a management point of view, inside a hospital where you're trying to manage a budget, it does make a big difference because you have these categories that have only one or two patients or no patients at all. One or two is hard because the payment rate doesn't give you much information about how best to manage those patients. So there's a debate, a tradeoff here. You can have more categories with more precision, or you can have fewer numbers of one and two patient categories. There's no right answer, in other words.

ED HOWARD: Yes.

MALE VOICE: My name is (unintelligible). I'm with (unintelligible) Davis' office. I'd like to refer to the Medicare gapping challenges, figure 7, again. You said figure 7 is important in terms of considering any prescription drug benefit proposal. What's the correlation between wealth and expenditures or income and expenditures for those high end Medicare beneficiaries, high end in terms of the two outliers, 8%, 10%? Would you say that those beneficiaries also represent the high end of income, substantial wealth? And what does that mean in the big sense of putting together a prescription drug

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TRICIA NEUMAN: That's a great question. The short answer is we don't know. The little bit longer answer is people with high health expenses go across all income groups. While people with lower incomes tend to have higher health care needs, it's not necessarily true that people with middle and higher incomes don't have high drug expenses as well. So--this is a guess--my guess is that you're looking at people who cross the income spectrum--maybe not the very poorest because they might be fortunate enough to have Medicaid; probably not those who are in employer plans who tend to be in the highest income group. So my guess is this would be comprised primarily of people who have modest income--the people who are somewhere in the middle because they're less likely to have Medicaid, less likely to have generous coverage from the employer plan. That's a long answer. I could say that what you ask is a good question that we should examine in terms of getting some understanding of what really is going on in terms of who is in these high spending groups.

MALE VOICE: When you consider studying a deductible for a prescription drug cost, we can look at the mean here as a genuine mean, not an artificial or in terms of being inflated by those people who have high costs and can afford to pay for those drugs.

TRICIA NEUMAN: Yes, this includes everybody.

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DIANE ROWLAND: But this also includes spending that may have been covered by Medicaid, may have been covered by insurance. So this is not the cost to individuals. This is the total spending these individuals had on their drugs. It's really the out of pocket costs that's the cost to individuals. And I think the other place you want to sort it out is you want to look at the difference in utilization between people with coverage and people without, and we do know that the people without coverage tend to be somewhat lower income than people with coverage, and we also know that they use fewer drugs because they have more barrier--they're more likely to skip a medication or to not fill a prescription, largely due to the income affect.

ED HOWARD: We have two or three questions--well, go ahead.

MALE VOICE: Thank you. Joe Patrie (misspelled?) from Congressman Allen's office. Talking about the general revenues that fund Part B--is that--I would guess there's a very basic answer to my question--but is that from the directly from the federal budget?

TRICIA NEUMAN: It's out of our tax dollars.

MALE VOICE: Thanks.

ED HOWARD: And that's exactly the kind of question that people should not feel any hesitation at all in asking. That's what we're here for. Another basic question has turned

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up in a couple of cards, and that is the age of eligibility, which for age based Medicare beneficiaries is 65. A couple of people have asked, well, look, since 1965, the life expectancy of people at that age has gone up substantially. Is this still the right age? We've raised it for Social Security. Shouldn't we raise it for Medicare? And the question is not necessarily yes or no, but what are some of the factors that should be taken into account for this factor to be legislated or not?

DIANE ROWLAND: Well, if you look at this from the flipside of our uninsurance problem in the U.S., one of the groups that has high rates of uninsurance are those between 55 and 65, and so we have a phenomena called waiting for Medicare because they can't afford the private insurance options that are available to them mostly because individual health insurance policies are age rated, and so the older you are and the more likely you are to need health insurance, the more costly that insurance will be, and many conditions that you have may, in fact, be excluded from that coverage. So some argue that Medicare should actually be going down in age instead of up, so that we can help to close some of the gaps in the private insurance market in the uninsured in that age group pre-Medicare. I think you obviously can look at a cost perspective of obviously it saves Medicare money to start people on the program later, but what does that imply for our other policy objective, which is to try and close the gaps in

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insurance coverage for our nonelderly population.

TRICIA NEUMAN: I'd like to add a little bit to that, which is this is an issue which has been debated fairly routinely because of the issues around making Medicare eligibility parallel to Social Security. But one point to keep in mind is the savings are not quite as great as some might anticipate because those who are coming on to Medicare are also at their healthiest and lowest cost, so the savings to Medicare, while it's not significant, are not as great as some would suspect.

ED HOWARD: You'd get more money if you didn't cover people between 72 and 75, right? Questioner asks that somebody explain the difference between participating and nonparticipating physicians in Medicare, and is it true that there are fewer of them now and that people have to pay more out of pocket?

JULIAN PETTENGILL: Well, I can answer part of that. A participating physician is someone who has agreed to accept—on an annual basis, physicians get asked whether they want to participate in the program, and they have to respond to CMS and say yes or no. Those who respond saying yes are agreeing to accept assignment of all of their claims of services, and what that means is that the claim goes directly to the carrier; they collect coinsurance from the beneficiaries—actually that's handled by the carrier, for the most part, directly; and they

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have agreed to not balance bill any beneficiaries during the year for services. If they refuse assignment, then they can balance bill, although the extent to which they can do that is limited. I think it's 113% of their rate. It's the Medicare fee schedule amount, it's the maximum amount they can balance bill. So that's really the difference. Some are accepting assignment and accepting the payment rates as payment in full, and getting their claims paid more quickly, getting them paid directly by the carrier. What was the rest of the question?

ED HOWARD: Which way is the trend? Are fewer physicians doing that? Are they getting a little more money?

JULIAN PETTENGILL: CMS publishes information about the responses of the physician community annually, and they come out some time in February, I believe. I don't know if this year's rates are out yet or not. Because of the potential for a rate cut in the physician fee schedule, this year that has been a big issue--what would happen to the participating physician rate. And MedPAC did a survey of physicians to find out what their likely responses would be, and the numbers were only slightly lower in our survey, but I don't know what the official statistics show at this point. That should be available soon, and I imagine it would be available on CMS's website.

ED HOWARD: Probably the other thing about physician rates that has been most on people's minds is the formula and

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impact on the actual amounts physicians would receive and what happened in the appropriations bill. Do you want to sort that out briefly for folks?

JULIAN PETTENGILL: My understanding is that in the appropriations bill, the Administration and the Congress reached a compromise--fix, I guess you could call it, to avoid the fee cut that otherwise would have occurred, which was scheduled to be 4.1%, and instead, for calendar year 2003, that physicians will get an increase of 1.6%. That whole situation was created by an attempt that Congress has made for years to control the growth in physician spending, using something called the sustainable growth rate system, which limits the uptake on physician fees. It's a cumulative system in which the increase in spending is monitored over a period of years, and depending on what happens to GDP--gross domestic product--in this case, gross domestic product went down, CMS made some mistakes in their projections, and the result was that the sustainable growth rate system imposed a fee cut of 4.1% to hold projected physician spending below the allowed cumulative level. And that's what the Congress fixed, but the fix is temporary in the sense that the projection for next year is minus 3.1, which may or may not turn out to be worse.

ED HOWARD: You did such a good job explaining that--

JULIAN PETTENGILL: I didn't think that was very good at all, but--

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ED HOWARD: This question from outside DC, one of the Congressional offices, which I think is our last question, [unintelligible]. Can you briefly discuss the ways in which Medicare supports physician training? And you don't have to answer the second half, which is do most people agree with this diversion of national funds to promoting professionals who, over a career, are very well paid?

JULIAN PETTENGILL: I don't think I will answer that. But Medicare support for medical education—graduate medical education—takes several different forms. One is that, for hospitals that operate approved graduate medical education programs, Medicare makes payments to the hospital on a per resident basis. These are perspective payments per resident. The amount the hospital gets depends on the number of residents it has, and Medicare's share of the hospital's total patient days. Another form of payment is that, in its perspective payment system, Medicare pays for something called the indirect costs of medical education. These are intended to cover the higher costs that teaching hospitals incur, that haven't incurred historically, related to operating medical education programs but that are not directly attributable to those programs. So, we've known for years that teaching hospitals have higher operating costs, and if you relate teaching intensity as measured by residents per bed, you find out that part of their higher costs is attributable to the intensity of

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their teaching programs. And Medicare makes extra payments inside the perspective payment system for that. So that's a second source of support. A third, and much more amorphous and general form of support, is in paying for all of the services in all of the settings where Medicare beneficiaries use services, and where teaching is occurring. Teaching doesn't just occur in the inpatient setting; it occurs in the outpatient setting; it occurs in a lot of it, actually, in VA hospitals and in outpatient clinics, and to some degree, even in HMOs. So, because Medicare is supplying payments for services in general in all of these settings, indirectly it's supporting these activities, and whether that's good, bad or indifferent, not my choice.

MALE VOICE: But it's a lot of money.

JULIAN PETTENGILL: It is a lot of money, yes.

ED HOWARD: Well, that's a pretty good comment on Medicare actually, and maybe it's a way to end this. We're talking about a lot of money to deliver a lot of services to a lot of people who need them, and we've been edified in a variety of ways by our panelists and our questioners about the aspects of this program. Let me quickly reiterate. I don't think yours is blue, but whatever color it is, would you fish the evaluation sheet out? It's green--thank you. And fill it out before you leave. Let me just take a moment to thank, once again, the Kaiser Family Foundation for its participation and

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sponsorship of this event. Remind you that next Friday we're going to do a program like this on Medicaid. And ask you to join me in thanking our panelists for what I think was a very useful session. See you next Friday.

[END]