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Briefing on CMS Ten-Year Health Spending Projections Health Affairs February 25, 2008

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JAMIE ROBINSON: Okay, let's go ahead and get started here. I'm Jamie Robinson, the Editor in Chief of Health Affairs, and I am very pleased to introduce to you today Sean Keehan and Andrea Sisco who are the senior authors of a paper we'll be publishing tomorrow on the CMS Actuary's ten-year projections for health care expenditures— basically, how things are good and getting better if you're a seller of healthcare services in America. And we at Health Affairs are very pleased to every year publish both the CMS's Annual Costs of Healthcare report, which we did in January for '07, as well as the rolling ten year projections.

I think for the first time this year— because they've been doing this for ten years now— CMS did a retrospective. How good are the projections? How good are ten-year projections? And the answer is, pretty good.

So with no further ado I want to allow them to take it away and tell us how things are going to look a decade from now.

SEAN KEEHAN: Okay, great.

MALE SPEAKER: Can I, just, before you start—

SEAN KEEHAN: Sure.

MALE SPEAKER: —make sure you understand that the material is embargoed for the briefing until 12:01 am tomorrow, the 26th.

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SEAN KEEHAN: Great, well, again, thank you for the introduction and thank you all for coming today. Again, each year we're really pleased with the coverage that we get for both this article and the projections article. And we provide the numbers, and we leave the debate to others. And your work in promoting the article and distributing it to people has really been helpful. So thank you again for what you've done in the past. And again, after our presentation we'll be happy to answer any questions that you have.

First, before we get started on the presentation I just wanted to quickly introduce our team. We might be calling on them to answer questions at the end of the presentation. And when they do, if we do call on them, then they will state their name again. But from the window down, we have Kevin Lyons, Chris Truffer, Kent Clemmons, Jonathan Solis, Cathy Cowan, Sheila Smith, John Wizell, and a special guest is our Chief Actuary, Rick Foster.

Jamie mentioned about the Projection Accuracy Report. It wasn't in your folder, but it is on the table outside. And for those of you who are listening to the audio version of this report, the Prediction Accuracy Report, if everything goes right, and hopefully it will, tomorrow morning that will be—the link is in footnote eight of the report, and that takes you to the NHE projections page, and halfway down the page is the download section, and you'll see projection accuracy there. So

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with that, let me start the presentation and Annie will be doing the first half.

ANDREA SISCO: Thank you, Sean. I'd like to begin with an overview of our main takeaway points that will be explained in greater detail over the course of the presentation. Our first finding is that we expect growth in national health spending to remain stable over the projection period, which is 2007 through 2017, at 6.7 percent per year. At the same time, we expect that economic growth will slow to approximately 4.7 percent per year. This combination of steady growth in NHE and slowing economic growth leads us to expect that the health share of GDP will grow to nearly 20 percent by 2017.

A steady outlook in overall spending growth does not necessarily imply that there is steady growth under all the underlying sectors and payers. Therefore we find that we are expecting divergent trends in both payers and sectors.

We are expecting a general acceleration in public spending over the projection period through 2017, and then a deceleration in private spending growth. Among the sectors, we are expecting to see an acceleration in hospital spending growth in 2007, followed by a general deceleration in growth through 2017, whereas prescription drug spending is expected to decelerate in 2007 and gradually accelerate through 2017.

Finally, this years report has a new feature that resembles a supplemental memo to the 2007 Trustees Report, in

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which we conduct a simulation where we test the effect of a zero percent update to the Medicare physician fee schedule as opposed to the negative update that was in current law prior to the passage of the Medicare, Medicaid and SCHIP Extension Act of 2007 that just passed in late December. And the results of that simulation will be given later on in the presentation.

This slide gives a pictorial view of our first major finding and some of the causation behind the second. As you can see, there is stable growth in NHE projected over the projection period of 6.7 percent. And again, you can see the GDP growth is expected to slow.

The differential between these growth rates is expected to be about 1.9 percentage points over the projection period. This is a larger differential than seen in 2004 through 2006, where the differential was about 0.3 percentage points. However, this is a smaller differential than was seen over the last 30 years on average, at 2.7 percentage points.

And again, the resulting expectation from stable NHE growth and slowing economic growth leads to the increase in the health share of GDP to 16.3 percent in 2007, which is our expectation, from 16 percent in 2006 to 19.5 percent by 2017, nearly one fifth of the economy.

Now, we'd like to talk a little bit about the diverging trends that we see underneath the steady growth outlook in NHE. We're expecting public spending to slow in 2007, and private

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spending to accelerate, as we know from the release of the historical NHE that the 2006 growth rate in public and private do reflect the implementation of the Medicare Part D drug benefit.

Over the rest of the projection period, we are expecting public spending to accelerate to 7.4 percent by 2017, and the acceleration towards the end of the projection period is attributed to the enrollment of the leading edge of the baby boom generation in Medicare.

Private spending, on the other hand, is expected to accelerate through 2009 and then decelerate over the remainder of the projection period to 6.0 percent by 2017 due to the expectation of lower economic growth.

Hospital spending growth, as stated before, is expected to accelerate from 7 percent in 2006 to 7.5 percent in 2007 due in large part to increased Medicaid payment rates, led to an acceleration in Medicaid spending. Over the remainder of the projection period, private spending is expected to slow, and this is expected to draw the overall expected slowdown in hospital spending, mostly due again to the expected slowdown in economic growth. Hospital spending is expected to reach 6.4 percent by 2017.

In terms of the share of NHE, we expect hospital spending to remain the largest payer, accounting for 31 percent

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of NHE in 2007 and 31.5 percent of NHE by 2017. And with that, Sean will continue discussing our major findings.

SEAN SEEHAN: Thank you, Andrea. Okay, so prescription drugs. In 2007 you'll see that there is a deceleration to 6.7 percent from 8.5 percent in 2006, and this is all due to slowed price growth. In the CPI for prescription drugs, the [inaudible] for prescription drugs for 2007 was 1.4 percent, versus 3.5 percent in 2006.

And then throughout the rest of the projection period there's a gradual acceleration expected, and there are two reasons for this. First, we do expect some gains in utilization because of lowered thresholds for treatments for conditions like cholesterol and high blood pressure. So coupled with the guidelines saying that if your cholesterol is this level, before we may not have treated you with a drug, now we will, couple that with an aging population, we do expect that's going to cause some increases in utilization for some therapy classes.

Secondly, as this graph shows, the last eight years there has been a big dip in the growth rate. A lot of this is explained by large increases in the generic dispensing rate, which in some years has gone up by four or five percentage points, which alone has slowed growth and has subtracted from drug spending growth by about two or three percentage points.

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Even though we do expect that the generic dispense rate will continue to increase throughout the projection period, the large increases that we've seen in the past are not expected. So that will allow for some utilization increases to actually show up in the growth numbers, whereas in the past few years they may not have been.

And finally we do expect some increase in the number of new drugs approved. Again, this is a very uncertain part of our projection, because we don't know what drugs are going to be approved in the next two, not to mention five or ten years, and what drugs are approved, what effects on spending they will have.

But we do know that FDA approvals have been at historic lows in the past few years, and there is a strong pipeline, especially for phase I and phase II drugs. So towards the end of the projection period, we do expect that there will be some new drugs, which will drive increases in utilization.

And now, moving on to Medicare. Medicare is projected to slow to 6.5 percent in 2007 from 18.7 percent in 2006. Again, the strong growth of 2006 is due to the introduction of Medicare Part D.

This growth of 6.5 percent in 2007 is a little below the average of the past few years. And one of the reasons for that is there were lower, smaller increases in Medicare

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Advantage Plan payments as a result of risk adjustments in 2007.

In 2008 we expect a bump up, a small increase in growth in Medicare, and this is mainly due to the expectation of stronger growth in Medicare inpatient hospital. And then towards the end of the projection period there is a gradual acceleration, and this is mainly due to the first baby boomers coming in to Medicare. And so this acceleration towards the end of the projection period is enrollment driven.

Okay, these next two slides talk about the simulation that Andrea mentioned in her introduction, and Andrea gave you a little bit of background but I just wanted to point out that in past years because there have been negative updates expected for Medicare physician payments, what we've always said in the projection is, we think that the Medicare projections are likely understated. And the feedback from folks like yourself has always been, "Well, can you quantify that at all?"

And we will always say, we really can't quantify it, but because of the supplemental memo that Kent Clemmons wrote in the 2007 Medicare Trustee's Report, as a supplement to the 2007 Medicare Trustees Report, his memo was on two illustrative scenarios for alternative physician payment systems. I believe it's end note 18 in the report.

And because of that we were able to actually piggyback on that analysis and complete a simulation of a 0.0 percent

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Medicare physician update scenario, which was one of the two scenarios that Ken wrote in his memo. And as you can see, by 2017, Medicare physician spending would be 25.3 percent higher than in the current law scenario.

And then if you go to total Medicare, the difference is a little smaller but total Medicare spending would be 6.4 percent higher by 2017 versus the current law scenario. And then if you look to the next line, which is the total NHE, to the health spending, the difference is 0.7 percent by 2017.

And so what this means would be instead of 19.5 percent health spending as a share of GDP like we have in our current law projections, it would be 19.7 percent. So it would only be 0.2 percentage points higher.

And before I move on I just want to point out the note that's at the bottom of the last two slides, and this basically says that our current law projections really only give the primary impacts of the Medicare physician payment negative updates, and there are some secondary impacts which are listed on the slide that are not included, and so I just wanted to point that out before we move on.

Okay, next we'll go into Medicaid. And you can see the dip in 2006, mostly caused by the movement of dual eligibles. The payments for their drugs from Medicaid to Medicare. And the bump up from 2007 to 8.9 percent growth.

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Now this growth again is a little bit higher than the average for the past few years, and the main reason for this is that Medicaid had implemented some provider payment whether freezes or cuts in 2005 and 2006. And so at the time the decisions were made for 2007 state fiscal conditions had improved. And so at this time, which may have been 18 months ago, they either lifted the payment freezes or removed the payment cuts and the increases in the payment rates are the main reason for this increase in growth. And again, you see it in hospital, which Andrea mentioned, the most.

As far as the rest of the projected period, the [inaudible] is averaging 7.9 percent, which is a little stronger than total health spending growth. And one reason for this stronger growth is that under the community-based waiver program, which is the program where states try to move state nursing home eligible people to get that care in the community instead of having to get that care in a nursing home the expectation is that expenditure for this program will continue to increase. And so that's one reason why the growth is high [inaudible].

Okay, next this slide talks about private health insurance. Premiums and benefits per enrollee. As you can see in the historical period, premiums and benefits have had a— there's been times in the past that premiums have been significantly higher or lower than underlying benefits.

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And in the projection period, we're actually not expecting this. Premiums being higher or lower than the underlying benefits is mostly due to the underwriting cycle where because insurers have to set the premiums typically 18 months before underlying benefits are known, there can be some errors in their forecasts, and so they're going to be either higher or lower than the underlying trend.

And so in the projection period we have an underwriting cycle, but some of the experts that we've talked to believe that the underwriting cycle will be milder because better information systems will allow insurers to better predict the trends than they have in the past. And so for the projection period we have premiums peaking in 2009, 6.9 percent, just slightly above underlying medical benefits, and then decelerating throughout the projection period, ending at about 5.9 percent by 2017.

This slide shows out of pocket spending, and the dip in 2006 is mostly due to Medicare beneficiaries who might not have had drug coverage in 2005 now having Part D, and associated with that, lower out of pocket spending for prescription drugs.

And then for 2007 through 2009 we have growth around 5 percent, and then throughout the projected period we have growth accelerating slightly to get to about 6 percent by 2017. And the reason for this expectation is that insurers and the employers are expected to— with future increases in costs,

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they're expected to more equally shift those costs to beneficiaries in the form of more cost sharing than they might have done in the past.

Because as you can see the historical period that the growth in out of pocket spending has not kept up with the growth in private health insurance spending. But because employers are feeling more of the— the cost is growing and it's becoming more difficult to face these costs, we do expect that in the projection period, at least by the end, we expect basically a convergence of the growth rate in private health insurance spending will be similar to the growth rate in out of pocket expense.

Okay, so the past four slides I gave the major payers, the outlook for the major payers. And so I just want to put this slide here at the end because I wanted to give who paid for health care in 2006 versus what our expectation is of who's going to pay for health care in 2017.

Private health insurance is expected to be the largest payer both in 2006 and in 2017, except it will go down a percentage point, so it's expected to be 33 percent by 2017. Medicare is expected to increase two percentage points from 19 percent to 21 percent, and so, you have the baby boom generation coming to Medicare, however it's not going to create a huge jump, at least for the next ten years.

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It's only going to increase a few percentage points, which some people have found a little bit surprising it's not more. But this is just the initial wave of the baby boom generation, so 21 percent is two percentage points more than the last historical year.

Medicaid is also projected to grow two percentage points from 15 percent in 2006 to 17 percent in 2017. And this is just as a result of the fact that growth is expected to average 7.9 percent per year which is a little bit more than a percentage point higher than total health spending, so that causes an increase in share.

Finally I just want to mention that out of pocket share is projected to go down by one percentage point; by 2017 it will be 11 percent. However, that does not mean that consumers aren't going to be feeling the pinch of higher health spending. They're certainly going to be, as I said in the previous slide, asked to share the burden more than probably in past years.

Okay, so finally I just want to reiterate our major findings, that Andrea went over earlier. We expect health spending growth to be steady throughout the projected period at 6.7 percent per year. And that, coupled with lower projected economic growth gets the health spending share of the economy at nearly 20 percent by the end of our projection period.

However, this stable growth is not for all payers. We have private decelerating with public accelerating and the

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sectors are not all constant, as well. As Andrea said, hospital is projected to decelerate while prescription drug spending is expected to accelerate.

Finally, the 0.0 percent Medicare physician update scenario that we ran this year showed total health spending going up by 0.7 percent by 2017 relative to our projected current law estimates. I think it had 0.7 percentage points and the growth by 2017, the cumulative growth is just expected to be 0.7 percent higher, and it's not a percentage point. And so that would— with that scenario, health as a share of GDP would still be a little bit under 20 percent: 19.7 as opposed to 19.5.

Okay, and so with that, that's our last slide, so we'd be happy to answer questions. Yes?

WILL DUNN: Hi, I'm Will Dunn and I'm from Reuters. Is there one particular area, looking from last year to 2017 that is most significant in driving the increase in health spending?

SEAN KEEHAN: Well, I guess I wouldn't say most significant. I mean, in the article we certainly mention that the baby boom generation coming into Medicare is going to have an effect on driving at least the public share higher, and that's enrollment driven.

And the reason that we chose this year to talk about it is for this projection period we have six of the years with some baby boomers coming in because they're going to come in

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starting in 2011. And so since more than half of the years there's going to be some baby boomers in the Medicare, we thought that it would be right to specify.

However, as I just mentioned with the Medicaid strong growth, that's also a reason. So I wouldn't say that there's just one significant factor but certainly strong growth in Medicare and Medicaid play a role. Yes?

MATT DOBAIS: Matt DoBais from Modern Health Care, and I guess this is more a question of curiosity, but with a weakening economy and talk of a recession down the road, would any of that play into projections here, and if so, what impact would that have?

SEAN KEEHAN: Okay, so first I want to point out that we don't have a recession forecast in our macroeconomic assumptions. We use, for the first two years of the projection period, we use the consensus forecast from the blue chip economic indicators, and again this was back in December, but they were at that time projecting slower growth in the first half of 2008, picking up in the second half.

And the current consensus is close to that. Maybe it's a little lower, but it's still not forecasting recession. So that's not something that's in our forecast.

But in past years, with slower economic growth, health spending has been relatively stable, and so it has— in the past we've seen that when if there is slower economic growth, it

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might cause the health spending as a share of the economy to increase because while general economic growth might fall, health spending might also fall a little bit but not probably as much as economic growth.

MARILYN SERAFINI: Can we assume, Marilyn Serafini with National Journal, we assume that we'd see that in programs like Medicaid and SCHIP?

SEAN KEEHAN: I'm sorry. See what?

MARILYN SERAFINI: If we did see larger health care spending or as a I don't know, related to the economy as a result of— if we did go into a recession, would we see greater spending, would we see that show up more disproportionately in programs for the low income such as Medicaid and Medicare?

SEAN KEEHAN: Well, okay, well—

MARILYN SERAFINI: That's where I naturally take it that it—

SEAN KEEHAN: Well, yeah, let me just move one of these background slides which I asked— this was a slide that the historical— that was used in January, and basically it shows the effect of the last three recessions. And really that's all we can speak to, is what's happened historically.

And so you're right that the Medicaid spending did increase during the recessions. But as far as what else— Chris, would you have any—

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CHRIS TRUFFER: To the extent that Medicaid enrollment tends to increase at a faster rate during economic slowdowns and recessions, there may be an acceleration in Medicaid as a result. To the extent it would reflect in SCHIP, probably not as much, since the program has fixed allotments on the federal side plus the state side as well. So you probably wouldn't expect to see anything at the SCHIP that are affected.

MARILYN SERAFINI: Now would there be a, if we did see an increase in Medicaid, would we then automatically see maybe even a decrease on the private side, as perhaps some employers maybe cut back on benefits, stop offering insurance— I mean, I don't know how quickly those sorts of things happen, but—

CHRIS TRUFFER: It's hard to say. A lot depends upon the magnitude and the length of anything in the economic cycle, so it would be hard to state at this point what sort of overall impacts it might have beyond the fact that historically Medicaid tendency has to [inaudible] slowdowns.

SHEILA SMITH: Just to add a little bit to that, private spending does actually eventually, [inaudible] very strongly [inaudible] so the reason why you see the health share rising generally in recessions is because health care tends to respond very slowly to changes in output and income. so that while you probably would see a little bit of a reaction in terms of slowing growth of private health insurance, I think it

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would generally be less proportional to [inaudible] which [inaudible] expect to see in a recession.

What you would expect to see is a reaction down the road. And based on our models, you'd expect to see lower growth about three years after the recession. In the context of our model, we estimate that the peak effect occurs about three years later. And the reason is that you have a lot of that effect comes through systemic change, which takes a long time to feed through the system. It has to occur through government action, through employer action, and all of that through contractual arrangements. And all of that takes a long time to happen.

JOHN REICHARD: John Reichard with Congressional Quarterly's Health Beat. Could you elaborate on the reason why private spending will relatively decelerate?

SEAN KEEHAN: Okay. Well, one reason why private growth will decelerate is the fact that you are bringing in baby boomers. As they go to Medicare, they're leaving private health insurance. So that's one reason.

And those will be— even though when they go to Medicare, they're going to make Medicare younger, they'll make the pool of private health insurance enrollees—

SHEILA SMITH: The enrollment affects that by reducing private spending, and aging actually slightly in the opposite

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direction. On balance, it tends to reduce private spending by a little bit.

SEAN KEEHAN: Right. The other reason in addition to that is we have a model, which Sheila could elaborate on if need be, that gives our private health insurance our total private spending growth patterns and disposable personal income is a main driver in that model. And our expectation with that is that growth will be slower in the projection period and that feeds in through the lag.

And so the slower economic growth as Sheila mentioned with the institutional changes, it takes about five years for income growth to fully be impacted, and so with our economic assumptions that's one reason. I don't know if you want to say more about that?

SHEILA SMITH: Private slow in growth and trend of [inaudible] growth in GDP and as a result disposable personal income and we see the effects of that in a fairly mild deceleration in private spending.

JOHN REICHARD: Did you say that the private insurance premiums would grow— I can't remember what the average yearly rate was. Was it five percent?

SEAN KEEHAN: No, the as far as the average rate, I don't think we have that on the slides, but it's— premiums is the— I know it might be difficult to see on the slide, but premiums is the orange line, and so that peaks at 6.9 percent

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in 2009 and so it's the 5.9 percent by 2017. I think that averages around 6.4.

JOHN REICHARD: But it's around five and six? Five and seven percent?

SEAN KEEHAN: Yes.

JOHN REICHARD: How does that compare with let's say the past 20 years? That's pretty low, isn't it?

SEAN KEEHAN: Yeah. Yeah—

SHEILA SMITH: It's not in real terms. It makes a difference.

JOHN REICHARD: But is there a difference in nominal terms as well?

SHEILA SMITH: Well, you go back to the growth in private health spending [inaudible] that you see, which is similar in that we expect growth to be faster in real terms than it has been in the historical years but substantially slower than it has been on average in prior history, in particular prior to [inaudible].

MARILYN SERAFINI: Do we have a comparison number for what this would look like if it was adjusted for inflation?

SEAN KEEHAN: We can try to look into that and if you give me your card, I can we can try to pull something together.

SHEILA SMITH: That would be easy to do.

MARILYN SERAFINI: Also, regarding the baby boomers and the— is the reason that the growth is not going up dramatically

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in Medicare I'm wondering if that has to do with one just simply the number of people that are coming in initially, but also does that have to do with the risk involved, because the people who are entering are the younger seniors? I mean, how much does it—?

SEAN KEEHAN: Yeah, it's certainly true that they— it's the first baby boomers, you're not getting the whole generation in obviously at first, and so— and they are the youngest, so they will have the Medicare population is getting younger, so per beneficiary the costs are going down.

RICHARD FOSTER: Let me add to that just a little bit. The first impact that you mentioned the greater number of enrollees, [inaudible] recently Medicare beneficiaries [inaudible] baby boomers—

MARILYN SERAFINI: Two or three?

RICHARD FOSTER: Three percent.

MARILYN SERAFINI: Three.

RICHARD FOSTER: So initially we get lots more beneficiaries, a faster growth rate of beneficiaries. The other side of what you said is also partly true, we're getting initial 65 year olds and 66 year olds, and they are not our most expensive beneficiaries on average.

Moreover, among the expensive 65 and 66 year olds many of them are already on Medicare because they qualified based on

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disability some number of years ago, so they're already there, they're not added to the acceleration in cost.

MARILYN SERAFINI: And if what everyone seems to be saying is that this generation, this baby boomer generation is more apt to work longer than their predecessors, and so if they continue with their private insurance, I'm assuming that has some effect also, to keep Medicare from zooming upward?

RICHARD FOSTER: It's a relatively modest effect but it's true enough that there's been a longish term trend toward people working to a little later ages especially women. That's a small effect that we've had, especially women [inaudible] higher ages than the past. The effect of that is much smaller.

But still, by the time you get to 65, the age of eligibility for Medicare, the labor force has gone down in [inaudible] by a lot compared with the older ages.

It's also true enough that if you get somebody that's still working at 65, and they work for an employer, I forget whether they have to have at least 100 employees, then the Medicare secondary payer provision kicks in, so there's coverage through that employer, they pay first. That itself is also common.

MALE SPEAKER: An important note to reinforce as well that the shifting of the baby boom generation into Medicare is not a reason for overall spending growth. It's sort of the underwriting reasons behind our decelerating private projection

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and accelerating public projections. It's not— the aging of the population itself is not making a terribly big contribution to spending growth overall.

MARILYN SERAFINI: So we're shifting it from private to public?

MALE SPEAKER: It's shifting from one category to another.

SHEILA SMITH: Not entirely but—

MALE SPEAKER: Not entirely, but it's relatively small compared to—

MARILYN SERAFINI: But can we assume that that's going to change as we go on? I mean, at what point does it change? What's our magic year, when it's really going to change?

MALE SPEAKER: Beyond this projection.

MALE SPEAKER: Right. That's always our scope.

RICHARD FOSTER: After age 75, on average, healthcare costs take off— they really start taking off after age 50, but especially after age 75, it's much more pronounced.

MARILYN SERAFINI: So ten years?

RICHARD FOSTER: Yes. Within the first ten years we're projecting [inaudible]. Watch out in the next ten years.

MALE SPEAKER: [Inaudible] any indication [inaudible] price and of use [inaudible] factor?

MALE SPEAKER: Factors accounting for growth?

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SEAN KEEHAN: Yeah. Right, so, Exhibit 4 in our article has— we broke down the accounting for growth into four factors, and prices is the largest factor, with utilization being next. And population and the age/sex mix are the smaller factors.

So a lot of people might report that the aging of the population is a driver for health care, and that's not what we've found, and that's not what other research has found. So really the biggest factor driving health spending is price growth, with utilization being second.

MALE SPEAKER: Get those numbers to me?

SEAN KEEHAN: Sure, absolutely.

MALE SPEAKER: The simulation at 0.0—

SEAN KEEHAN: Uh-huh?

MALE SPEAKER: That's the smallest factor. But it's hard to get a fix on what that's [inaudible] six month plus [inaudible] percent then you've got a much larger [inaudible]. What I'm trying to get at is say if where there's a [inaudible], whether it's one percent or two percent growth in physician payment over the next projection period. Can you get an order of magnitude sense of what the impact of that would be as opposed to the one or two percent and 0.0 ?

SEAN KEEHAN: Okay, so first off, as Andrea mentioned, we do not— we weren't able to include the 0.5 percent for the first six months of 2008 because that was passed after we finished our projections. So we only did this simulation for

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0.0 percent, and as far as speculating what it would be if it was one percent or two percent, unfortunately we didn't do that.

Because people had asked us, quantify how much of the projection is likely understated, we just gave one scenario and the other scenarios— we really can't speak to what that effect would be, because we didn't run those numbers.

MALE SPEAKER: The other part of that is that it's not a relationship between like the zero percent theoretical illustration he gave, it's something higher like one percent. You think, okay, should we add the difference to one percent on top of the [inaudible] is it the wrong thing to add? Because under current law, what does it go by? The [inaudible]? For this year?

MALE SPEAKER: [Inaudible]

MALE SPEAKER: Okay, so from the highest point of 2008, where we start at 2009 is minus [inaudible] percent. And then going for several years after that, further reductions of five percent for a number of fifth years, if you think about it, pumping that up to zero percent, what would otherwise be minus 15 plus all those fives, that's a big change. If you go then an additional one percent, that's a small change on top of that. How could the net effect then be so small? [Inaudible]

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RICHARD FOSTER: The charts are in there. If you look at the impact on [inaudible] position [inaudible] is actually quite large. If you look at overall-

MALE SPEAKER: It's just-

RICHARD FOSTER: -effect on health expenditure, it's [inaudible].

MALE SPEAKER: Okay. Okay.

SEAN KEEHAN: Yeah. And then, the key to the presentation is, you can see that the Medicare position- how much it's understated, and it grows throughout the projection period, being 25.3 percent by 2017. And then, total health spending, which is on the next slide, relatively small at just 0.7 percent by 2017. And really this is the first time that we've done this analysis.

Rick raises a very good point about how an effect on one year, you increase the payments one year, it doesn't change the system. So there are just going to be negative updates for many years afterwards. So it's an important point to make, and so we're just really happy to be able to, because of the piggybacking off the supplemental memo, just give one number that might give a perspective on how much these projections might be understated. Unfortunately, that's all we can do, there.

MALE SPEAKER: That answers the question as to physician payment, but [inaudible] blow up [inaudible] Richard.

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SEAN KEEHAN: Matt, you had a question?

MATT DOBIAS: Oh, I do, right. From one provider group to the next, I wanted to look at the hospital spending and some of the projections there.

SEAN KEEHAN: Okay.

MATT DOBIAS: Can you go into some of the factors that are impacting hospitals right now that I think the projection is a slight increase and then a deceleration of growth?

ANDREA SISKO: Sure. As I mentioned, one of the primary drivers of the 7.5 percent expected growth rate for 2007 is increased Medicaid payment rates. As Sean was mentioning, states had, post the last recession, did have some payment freezes or cuts in place.

Those were lifted and then that led to again higher payment rates for fiscal 2007, which led to an acceleration in 2007. That's the main driver there.

And then again, the deceleration over the remainder of the projection period is mostly attributable to the expected lower private spending growth trend. There is a bit of an acceleration in private through the end of the projection period again that idea of the leading edge of the baby boom generation, but it is somewhat modest. But again, as Sheila was mentioning, in terms of what drops that private spending trend is sort of this lag response to changes in income, changes in the economy.

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MATT DOBIAS: Where is that private dollar expected to go, if it's not going to go to hospitals? Would it go to outpatient care, or other places where they can get services other than a hospital?

ANDREA SISKI: That is an individual decision that is not included in this particular projection.

SHEILA SMITH: The growth in hospital spending is actually growing faster on account of the slightly greater share of the health dollar by the end of the projection [inaudible]. I think that's—

ANDREA SISKI: That is true.

SHEILA SMITH: And that is relatively faster growth in hospital spending [inaudible] patient [inaudible] 1984 through 1990, it continues a trend that we've seen from the late 1990s of relatively faster growth.

SEAN KEEHAN: Yes.

MALE SPEAKER: You talk about the methodology of these projections similar to the Social Security Medicare Trustees Report [inaudible] significant differences [inaudible] in common.

SEAN KEEHAN: The methodology of the Medicare Trustees Report— we used their Medicare projections. We take those as given and we have to crosswalk it so they meet the terms of how the national health expenditure accounts are defined. But we don't make any changes to them except for aligning the terms

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correctly. And then we also use the Medicaid projections that are used in the president's budget as well.

But then as far as our methodology, what we do is we have models for private health spending and also other public health spending. And those are metric models and so we use those we've had a history of them, we try to improve them each year.

So it's a different type of modeling than might be done in the Medicare Trustees Report, but we certainly look at these reports and this projection accuracy report has given us further incentive to make sure we're not having any bias in the models. We try to make the models as accurate as possible. Sheila, I don't know if you want to mention anything else?

SHEILA SMITH: Just basically the question that we attempt to answer is given the outlook for Medicare Medicaid that comes out of the Trustees Report, and other exercises and also the macro picture, what can we expect for private spending? And it's to some extent a wraparound projection. And there are relationships between private and public spending that we take into account. But largely our focus is on the private spending.

JOHN REICHARD: You had mentioned that one of the factors in Medicaid spending accelerating rate of Medicaid spending growth, that this is partly a reflection of the shift

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to home and community based care. This seems to be contrary to what advocates of that say, anyway, that it would save money?

SEAN KEEHAN: Oh, okay. It's— again, we can't speak to whether it would save money or not, but we know that it's in different buckets in the national health expenditure accounts. So, the home and community-based spending for that is in a "other personal healthcare" category. Versus the nursing home category, which is what nursing home expenditures are in.

So we don't— we know that states have— the expectation, from interviews with state Medicaid officials, is that they'll continue to try to push that, because I'm assuming they expect that that will save money, but it's in different buckets, so we see an increase in other personal health care in Medicaid because of the home community based waivers, and Medicaid nursing home is a little bit lower. Chris, I don't know if you want to elaborate on this at all?

CHRIS TRUFFER: No, there is a [inaudible] that generally reflects preference for a state to use community based care and home health care for their long term care needs. So we are expecting to see strong areas of growth in that area.

JOHN REICHARD: Is Medicaid technically the primary payer when it comes to home health services?

CHRIS TRUFFER: Medicaid and Medicare.

SHEILA SISKO: Medicare, primarily.

SEAN KEEHAN: Yeah.

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CHRIS TRUFFER: About three quarters of home health care.

SHEILA SISKO: It's the combination.

CHRIS TRUFFER: Medicaid is certainly one of the strongest, biggest payers in long term care overall as well, sure.

SEAN KEEHAN: Yeah, I have the numbers in front of me, Medicare in 2006 paid for 37 and a half percent of home health care, and Medicaid combination paid for about 33 percent. And then the projection period, the numbers are similar, so together, Medicare and Medicaid definitely pay for the largest share. Another question?

MALE SPEAKER: On almost all your graphs, the big difference between the past and the future is that the past, all these numbers are very cyclical and the future projections have no cycle to them. And is that because there will be no cycle, or because the models don't have cyclical affects on them, or— I mean, it's striking. So I'm not talking about the underwriting cycle, I'm talking about the actual cost numbers.

SEAN KEEHAN: Right, right. Well, as I said before, we have— our macroeconomic assumptions are based on the Social Security Trustees Report, the 2007 Social Security Trustees Report, and then we use for 2007-2008 the consensus of the blue chip.

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And so basically, that's what they project. There's no recession forecast in there, and there's no boom period or growth where it's expected to be substantially higher than the average. So our macroeconomic assumptions don't have a cycle. So we certainly are not going to change our macroeconomic assumptions just to put one in where—

MALE SPEAKER: But also, the health care cost expenditure assumptions, they're all flat? That's a good—

SEAN KEEHAN: Well, if— our biggest variable, which we've found driving health spending is disposable personal income growth. And the relationship between GDP growth and personal income growth is pretty stable.

And so since there's no big jump in disposable income growth, we're not going to add a big jump in models of— in this private health spending growth— yeah, go ahead.

SHEILA SMITH: Just a little bit? There usually is a cycle in the [inaudible] private spending. And that reflects the [inaudible] of personal income and [inaudible] in particular. We [inaudible] average. Those are the macro assumptions. We eventually reach a forecast.

So what you see is, whatever's in the pipeline historically [inaudible] disposable personal income, feeds through and affects health care spending over a period of five years, and then [inaudible] to a trend in demographic population density. So that's what you can expect to see.

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In this case, the pattern of growth of disposable personal income over the past few years has been pretty choppy because there have been some substantial effects of things like tax [inaudible] and it hasn't tracked exactly. So it's really almost by accident that when you take the [inaudible] average that feeds into our metric model in this case it produces a line that's almost flat.

It's not precisely flat; there's a slight cycle. And you have factors at the beginning and the end which tend to push growth up a little bit. So the net effect of all of those factors is a very flat forecast. But that may well be the case in terms of the-

MALE SPEAKER: I'd be certainly interested in seeing a chart some other time of what your past ten year forecasts were- literally, what did it look like- was it also flat? I mean, does the methodology drive it towards it because of the average moving average or have we tamed the beast here of the volatility of health care? Or is it just-

SHEILA SMITH: The five year moving average is a very good predictor of health care spending growth.

Uh-huh?

And it's largely for that reason that we have such a good record of accuracy [inaudible]. And because we have that chart in there, we've generally had a bit of a cyclical pattern in the past few years, at least on the private side. We've got

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the feed through effects of the last recession. And then going into a period of higher growth [inaudible] the past two years where growth has been stronger. So you have seen a bit of a cycle. And that would generally tend to be the case.

That model has essentially been in place since the first forecast that we did on this basis in 1997 with some slight changes along the way. So that if you take a look at that article in particular, it will give you a pretty good idea of where our forecast will be.

And you can look at the successively the forecasts that we've produced over time and see how this cycle has changed. And in many cases the change is accounted for by changes in the macroeconomic data or the projections tables variables.

RICHARD FOSTER: Another point that speaks to your question regarding the volatility relatively speaking, whether it's smooth or it's— For things that we know, for example, when we project things under the current law, those can be reflected into the output of the models.

There are certain things that are unforeseen and there are certain things that you get feedback from various experts from around the healthcare industry that help us to better inform ultimately where our projection goes, and I'll use drugs as an example.

Frequently we're told about certain drugs, that are going to treat particular things— like obesity, for example—

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are in the pipeline but the expert opinion is not specific enough to target that those drugs will hit the market in, say, 2009 or 2010 but rather in the next two to seven years.

And so when we examine and analyze the results of the models that we have that build in to the projection of fundamentals that have been observed over time, we observe what that resulting projection is, we can sort of add factors, what we call our up and down, slightly, to try to build in to the expert opinion that we get. And one of the things that we're careful not to do is to imply specificity that really don't have.

And so ultimately, as you go out, each year's projection is intended to reflect the probability of these things coming into play as we move forward, which again results rather in a less volatile projection than—

SEAN KEEHAN: Yeah. And one other thing— I have the private public slide out, because the big ups and downs in the public, a lot of it has to do with legislative changes, and so, our projection's on a current law basis, and so we don't have any BBA or anything that might cut growth or NNA that increase growth in 2006. So because we don't try to anticipate legislative changes, that's another reason why the growth is basically stable in the projection period. Do you have something else that you wanted to say?

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SHEILA SMITH: Oh, I just wanted to bring up one last point which I think is really interesting on the projected trend, which is that the current medical prices is pretty important [inaudible] because if you look at the historical data on price inflation over the past about 13 years, has been quite different than it was in the period through 1995.

The question is, what's going on there? Do we expect it to return to its historical trend? And the assumption that we have embedded in our forecast is that the answer is somewhere in between. There are a couple of factors that feed into this. One is that physician [inaudible] has grown more slowly, relative to overall professional and technical. And in our projection we assume that ultimately by the end of the period we're forecasting, that converges. We end up with— ultimately physicians have to grow at the same rate or there will be complications. And the result is that [inaudible] price inflation accounts for a larger share of growth, slightly larger share of growth over the next ten years than it has over the past ten years. But that's really a matter of clarification of historical data. The interpretation that we place on particular prices—

MALE SPEAKER: Robert, did you have a question?

MALE SPEAKER: Physician income grew in your projection?

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SHEILA SMITH: Over the last ten years. For the past ten years, physician income tended to grow more slowly than professional technical income as a whole. And so the assumption is that that can't go on forever without ultimately affecting the supply of physicians. So that in the long term private ten year end of our horizon, the rate of growth will converge.

FEMALE SPEAKER: You're talking about— when you say professional technical workers you're talking about—

SHEILA SMITH: I'm talking about— there's employment cost figures that are published— it's for all the—

FEMALE SPEAKER: So that's—

MALE SPEAKER: Not just in health care.

FEMALE SPEAKER: Right.

SHEILA SMITH: Not just health care. All professional and technical throughout this time.

SEAN KEEHAN: Yes?

ALIZA MARCUS: Aliza Marcus of Bloomberg. I just had one very simple question. Is out of pocket spending the same as personal healthcare expended? Essentially?

SEAN KEEHAN: No. Out of pocket spending is the co-payments and deductibles that you might pay at the point of service. Personal health care spending would also include not just out of pocket spending but would also include what private health insurance would pay for, but also what Medicare would pay for, what Medicaid would pay for.

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Personal health care spending encompasses all payers. So it would include in that what the other payers would— including other public, which is VA or DOD.

So out of pocket spending just includes co-payments and deductibles that you pay at the point of service. It does not include what you pay as the employee's share of the premiums, as you pay for private health insurance. It does not include that.

MALE SPEAKER: It also includes expenditures that you are [inaudible]. So if you went to see a physician and you did not have insurance, what would you pay out of pocket?

ALIZA MARCUS: Uh-huh.

MALE SPEAKER: So it's all out of pocket, irrespective of— direct out of pocket. Irrespective of your coverage.

ALIZA MARCUS: But it doesn't include what you pay for your insurance.

MALE SPEAKER: Why not? Why don't you use the term health spending rather than personal health spending?

ANDREA SISKO: Personal healthcare spending is actually a subset of NHE, and that covers any service or product that is dispensed in the care of an individual person. So that would be hospital physician, nursing, home health, prescription drugs, medical durables, non-durables.

And then NHE also consists of the rest of the non-personal health care, consists of things like government public

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health activity, research, construction, etcetera. So these are really subsets of total healthcare spending, but this gets to the actual healthcare provision to an individual.

MALE SPEAKER: So personal healthcare spending, sorry, includes what Medicaid pays, Medicare pays, VA pays. So the only difference in national health expenditure would be the difference that that includes construction, research and other things, right?

ANDREA SISKO: Right. Exactly. It's sort of looking at it not necessarily in terms of payers, it encompasses all payers, but looking at what is being provided.

MALE SPEAKER: Personal health care is, what, 90 plus percent of the total of health care expenditures.

JOHN REICHARD: So what this data seems to be saying is that without the baby boomers being a big factor we're going to see a doubling of health care spending in the next ten years and price is the biggest factor explaining that?

SEAN KEEHAN: Yes. Price has been the biggest factor historically. And so price is also predicted to be the biggest factor in the next ten years. As far as the growth in prices, the average is around 3.7 percent for the projection period, so we'll leave it to others to determine whether that's relatively high or low, but it is projected to be relatively stable, and so— but the finding is that over the projection period, we

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believe that the biggest factor is price, which has also been the biggest factor in historical—

RICHARD FOSTER: And John, also think of it this way, over a particular period, if something is growing at seven percent per year, then the level of that something doubles in ten years, it doubles in size. And that's about the average period of growth we have for all these [inaudible], which is why they double.

Now the more interesting question is, is that unusually fast or slow? It's sort of in the middle, its fast [inaudible] and a few things are going a little faster than seven percent. But that's a good baseline to keep in mind: overall, seven percent is not out of line with what you normally think of for health care spending

MALE SPEAKER: The growth in the prices— now, part of that is wages and part of that is prices, like the prices of drugs, prices of— what's the split? Are they both growing at the same rate in your projections, or is one of them outpacing the other?

SEAN KEEHAN: Is your question “Is wages—”

MALE SPEAKER: Well, part of the increase in prices is nursing wages, physician earnings, and part of it is the price of drugs, the price of the objects and the change in the mix of objects towards more expensive objects or cheaper objects.

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SEAN KEEHAN: Right. We have— I can tell you looking at our numbers here that drug price growth is expected to be around 3.7 percent per year, so that's basically the same as the total. Hospital—

MALE SPEAKER: Price growth only?

Yes, I'm sorry, price growth only. Right. And so hospital— it looks like it's a little bit lower than 3.7 percent, maybe it's around 3.6 percent, the average growth rate, the average hospital price growth rate.

However, physician is a little bit higher at around— physician price growth is projected to be a little bit higher at around four percent, and a lot of this has to do with what Sheila had mentioned as far as our expected convergence of income growth— convergence with professional technical workers in the projection period.

SHEILA SMITH: The main determinant of the medical price information is an index of medical prices which is based on the [inaudible] reflect the composition of costs for each of the different settings.

So you could have a different weight for example, shifting the weight on drug purchases within hospitals, and that should be reflected. In general, it has been the case that relative growth and compensation is the most important factor, partly because it's a large factor, but also because it's more

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specific to the health sector and relative growth would be determinant of relative price inflation.

And because we are making the assumption that physician income will ultimately converge with professional technical occupations and therefore grow faster than it has been over the past ten to twelve years, then ultimately that cost will rise, that price will rise a little bit faster than it has been historically.

MALE SPEAKER: So you're saying what is interesting on the CMS web page if you search on that you'll see the various price indexes and the cost rates that are associated with and reflect wages and salaries like prescription drugs all the way down to the cleaning solutions that you have to buy to operate a nursing home.

MALE SPEAKER: There's not a very easy, short answer to your question.

MALE SPEAKER: Damn. [Laughter]

SEAN KEEHAN: Any other questions? Okay, well thank you all very much and thank you for all your colleagues, and we look forward to publishing this paper tomorrow and you'll see it online at HealthAffairs.org tomorrow.

ANDREA SISKO: All right, great. Thank you.

MALE SPEAKER: Thank you.

[END RECORDING]

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