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**Forgotten Americans: The Future of Support for  
Older Low-Income Adults  
Lessons Learned From Administering  
Public-Private Delivery Systems  
NSCLC and Center for Medicare Advocacy  
October 19, 2007**

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[START RECORDING]

**JUDITH STEIN:** One more housekeeping message. Before - when we break we will have lunch and I hope that Michael, who's resting, as many of you know he had quite a serious accident this late spring and he's really very brave to be here today. And we will try and be sure that he's with me again in time to cut our mutual organization birthday cake.

So as we like to talk about our combined 553 years of experience, the birthday cake is our 56 year - combined years - and I think we may even get the candles on it, so. With no - Linda anything further?

**LINDA:** [Inaudible].

**JUDITH STEIN:** The next session segues well, as we had hoped, from the earlier one. We're going to be focusing now on the proper roles or the appropriate models for public and private entities to deliver public benefits to low-income older people and people with disabilities and for that matter to deliver public benefits such as financial security and health security programs to people.

We have a remarkable, wonderful person to speak to us about this topic in Bruce Vladeck. We're going to try and see if there is in fact a proper role for choice, a proper role for public and a proper role for private sectors and when are those sectors, the public and private sectors appropriate, when

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should they blend, when should they pull themselves apart and do different things, can they do work on one mission in a blended way or do they have to be in different silos. When is choice good? Is there such a thing as too much choice? And how can we be heard as we come to conclusions about these very significant issues.

Dr. Bruce Vladeck is the former many things and the current major things too. [Laughter] Many of you know that Dr. Vladeck is the former administrator of what is now CMS and I will say Bruce was the administrator of HCFA, of the Health Care Financing Administration. HCFA was a slightly cultural organization than CMS, the Centers for Medicare and Medicaid Services, which is the same agency under different leadership in the current administration.

When I met - had the honor of meeting with Dr. Vladeck at HCFA a number of years ago, seems like another lifetime and in a way it was, I recall him saying that he had spent the first part of his tenure thinking through a reorganization and who was the agency's primary customer. And I must say at the time I thought, duh Bruce [laughter], the beneficiary. And that's what he had concluded and that was the focus of Bruce's administration at the Health Care Financing Administration.

I have to say that I've gotten wise enough to know that that was a really brilliant thing to do when one came in to run

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an agency. To get everybody on board, to understand that the target, the focus and the mission of that agency was to do what need to be done for the beneficiary. And then we bring in all the other others, we call them these days, stakeholders to make sure that that target is reached. And Dr. Vladeck did that. That is the way in which, Tricia Neuman just said, he has a way of honing into the issue and he did that then.

As many of you know, he has been, until very recently, the Interim President of the University of New Jersey School of Medicine and Dentistry where he also honed in on some very significant issues and has brought that university - returned it to being a leader in delivering education and the medicine and dentistry areas. And he is now, as you see in your bio section of your notebook, at Ernst & Young, again, and now in the capacity as Executive Director of their Health Sciences Advisory Service Division where he's also the Senior Health Policy Advisory. And he rejoined Ernst & Young in September, 2007.

I am honored with the time that Dr. Vladeck has given us today and the graciousness with which he responded to my invitation. Bruce? [Applause]

**BRUCE VLADECK:** Thank you very, very much Judy for that kind introduction. I'm really very pleased to be here this morning to be part of this birthday party and this celebration

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with a lot of - I no longer use the phrase old friends, a lot of friends of long standing [laughter] and colleagues and like that. Although I would point out that most of the people in the room, I'm pretty certain, have some connection of one for or another to the center or to the NCSC, but I'm probably the only one in the room who is a former defendant [laughter] and I think that has a - ought to have special cache to it [laughter] as well.

I'm also however, exquisitely sensitive to the fact that my presentation and any questions people might have about it is the only remaining obstacle between this group and lunch. So, I will try to keep that in mind as I go through this stuff.

I really - my excuse for not having PowerPoint is nowhere near as good as Marilyn's. But I really struggle quite a bit over the last number of weeks as once a week roughly Judy or her colleagues hounded me about where my presentation was about exactly how to address these issues and how to make a presentation today. The question about the appropriate roles of public and private sectors and more appropriate relationships between public and private sectors and delivery of a whole number of services, including healthcare has - is obviously something I've spent a very long time thinking about from a number of different perspectives in a number of ways. And it's obviously as well a very, very important question, but

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I think as some of the discussion at the end of the last panel made clear, my sense is that the public discourse around these issues has become so distorted and so full of sound bites and slogans and so largely without any substantive content. And frankly, so riddled with the acceptance of statements or assertions or beliefs that are simply not true that I didn't know quite how to address that in the more appropriate way. And frankly how to keep my patience and temper in talking about some of these things.

So after really struggling with this for quite a bit, I decided that what I'm capable if I had Stephen Colbert's skills I could probably do a more appropriate talk about much of the discussion of this issue in Washington. But, since I don't, what I can do is just sort of describe for you in the context of the Medicare program or the case the Medicare program some of the facts of the relative to the roles of public and private sectors and their relationship as I've seen them and I've experienced them.

And further, I have to say that the older I get and the more cynical I get, which I don't know if there's a necessary correlation, maybe Claire or some of the other experts in geriatrics can tell me if that's biological or a function of the time in which we live, the more suspicious I am of any

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broad sort of generalization or conceptual schemes about some of these issues.

I recently had a very long conversation with my younger daughter, who is spectacularly talented young woman at the age of 24 is the policy director of a small non-profit in South Florida, and we were talking about issues of privatization in the delivery of social services in the State of Florida. And we finally concluded that if it was done for the right reasons by the right people, it could actually be a significant benefit in certain functions that government's done do well. And if it was done for the wrong reasons by bad people, it would probably be a disaster. And I think as Bob Greenstein pointed out awhile ago, we can - we are increasingly in an era where we confuse what governments are capable of doing or not capable of doing with what the people who are running the government had been doing or not capable. And that of course, creates a very one sided and distorted perception of some of these issues.

So I have a few concluding remarks, which you all be delighted when I get to them, [laughter] about some of these issues. But I don't have a grand theoretical scheme to provide to you today, although there are a lot of good ones in the literature and there's a lot of very good theory in social sciences about some of these things, but nobody cares. So I'm not going to waste a lot of time on that.

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So I'm just going to try to describe some things, do my sort of Jack Webb imitation and just the facts at least as I perceive them and then I will conclude with a few observations about why in the face of these facts we seem to be doing the kinds of things we are doing which would seem inconsistent with them.

So let me just sort of go into that. I think you all know, although for some of you, it's a more second hand kind of knowledge than for me and Ted and a few other of us around here that Medicare has been built on a public private partnership since its inception. It was a system designed to provide a public insurance vehicle to pay for services provided largely by private sector and private providers.

An interesting footnote in that regard, that's worthy of a whole 'nother discussion in itself, but not here, if people were taking this issue of public private seriously from an intellectual point of view is the extent to which by law Medicare has always explicitly not covered services provided by the two largest public healthcare systems in the United States, that operated by the Veteran's Administration and that operated by the Department of Defense.

And which if you go back further, the original Social Security Act forbade payments to residents of public institutions as an effort to do away with the old indoor relief

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history of public poor houses and so forth and bring American social welfare policy up to where the British policy had been since the 19th century.

So, this distinction between public and private goes back the very roots. Obviously as well the actually day to day administration of much of the Medicare program since its inception has been done by private insurance firms. Although, historically most of them were non-profits, as the insurance industry has evolved over the last decade that shifted quite a bit.

And if you read the histories of the Medicare program that's widely and not inaccurately described as a SOP or a political payoff to the American Hospital Association and a way to split the American Hospital Association off from the AMA and the politics of the enactment of Medicare because at the time in most of the country, the hospital community, hospital industry controlled most of the Blue Cross plans and were very comfortable with them and in fact the law is very much tilted towards the Blues and towards hospital nomination of their own intermediaries. And there was no question there was an explicit political calculus associated with that.

At the same time if you stop and think about what the contractors actually do and what it would have entailed for the government from scratch to recreate the kind of very highly

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decentralized, very highly localized mechanism for dealing with individual providers in every village and dale across the United States. I think you might even be able to make sort of a cost effectiveness argument for working through an existing infrastructure in the insurance industry as opposed to creating one from scratch.

Similarly, in the statue partially in deference to the provider community the basic quality assurance mechanism in the Medicare program through the certification of individual institutions is eligible to participate in Medicare was delegated to the private sector in the terms of what was then the Joint Commission on Accreditation of Hospitals. I think there the sort of high priority argument for having done that was not as quite as strong given how weak and ineffectual the Joint Commission has been through most of its history.

But some of - there was an existing infrastructure in place and it would have cost a fair amount of time and trouble to build on it. And the other thing that people tend to forget is that private plans like Kaiser Permanente or the United Mine Workers Health Insurance Fund have participated in Medicare since its inception as well. This is nothing something that sprang full blown out of the brains of the Jackson Hole Group or something like that, they were part of the healthcare

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delivery system prior to the time Medicare was created and they were incorporated in to it from the outset.

Now with the program that's now 47 years old we have a lot of experience around some of these choices about the relationship between public and private and I think we can draw some general conclusions. And there is a lot of data behind them although I will focus at sort of the very high level generalization kind of things, so if anybody challenges me I can defend it being a high level generalization.

But, I think in general to the extent we have the measures, which most of them are much more recent than most of this history, the private hospitals have outperformed the public hospitals in terms of certainly measures of customer satisfaction and probably in the quality measures we have had. Although, two important caveats associated with that, they have served very, very different populations and the public hospitals in many parts of the country have been essential providers of access to services to people who otherwise wouldn't have them

In addition of which, one of the sort of hidden stories of what's happened in healthcare in the United States over the last decade that because it runs contrary to the prevailing rhetoric, we don't hear very much about, has been the transformation of public hospitals both at the national level

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and the VA system and in a variety of communities around the country, including I'm proud to say in the public hospital system that's the Health and Hospitals Corporation in New York City where now the data shows that in the number of important measures of the performance of clinical services, the provision clinical services to their patients, the VA now systematically outperforms a large fraction of the private not for profit and for profit hospitals in the United States.

And similarly on a bunch of measures the Health and Hospitals Corporation is now outperforming many of the private not for profit hospitals in the City of New York. This has been a below the radar screen transformation that has a number of things associated with it, including interestingly enough the more rapid adoption by the VA and public hospital systems like HHC of modern information technology in the management of their institutions.

On the sort of contractor, the administrative side I think it's a complicated issue on which there's a lot less stated. But if you look back over the history of the administration of the Medicare program and Tim Jost [misspelled?] may be the only person in the world who's really interested in some of these questions, so there's not a whole lot and he's a lawyer, so there's not a whole lot of data [laughter].

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But, the performance of contractors has been pretty mediocre on average I would say probably some of that has involved outright conflicts of interest, which is one of the problems you have when you contract with the private sector to perform a government function. The most significant and recent of which, which it's hard to imagine anybody being really terribly interested in is the absolute unwillingness of the private plans, it's really the Blue plans to enforce their contractual and legal obligations under Medicare's secondary payer provisions adopted in the late '80s and early '90s as budgetary provisions because they were the ones who would - their private businesses were the ones who would have had to pay the money back to Medicare. And a lot of that stuff is still tied up. Of course, they've also, now under Medicare Plus Choice, Medicare Advantage have been directly competing with fee for service Medicare in a variety of places and that's created a set of problems all its own.

On the other hand, well the performance of the private contractors I think has been less than stellar on average. I think it's also true that the oversight and support of the private contractors by the government has also been less than stellar through much of its history. There's no such thing as benign neglect when you're paying people hundreds of millions of dollars a year, but there certainly was neglect.

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There also was really excessively stringent budgetary treatment of them because of the underlying problem in Medicare administration with which I expect most of you are familiar that benefits are paid out of trust funds, but the administration of the program comes out of annual appropriations which are subject to whatever caps or pay-go requirements or whatever happens to be in place at the time.

So there was a long period of time in the history of the relationship between the federal government and its Medicare contractors in which they kept adding expectations and requirements on the contractors every year and not paying them any additional money whatsoever. And then when many of them failed to meet it, there was a lot of conflict back and forth. So neither side I think gets gold stars for their management of that relationship over time.

And again, I think the — all the way back into the '70s when we begin to have PAITA [misspelled?] we see those private HMOs or then called Pre-Paid Group Practices participating in the Medicare program providing a reasonably high quality of care, significant beneficiary satisfaction and being more expensive than the fee for service system to some extent because their benefits were more comprehensive and the out of pocket barriers to care were not as great.

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As all of you know, in the mid '80s Medicare began paying HMOs and a few other private plans on a formula perspective basis. We have tons of data about that and I think there are a lot of conclusions. One which I think people in the advocacy community have to be really careful about is that we have a lot of data on sort of clinical performance and what the data show is that on average, compared to the fee for service system in the same communities, the private plans of Medicare have not done a bad job. They have done less well on chronic care and serious illness than they've done on routine care and preventive services, but that's truly the fee for service system as well. And there is sort of a normal distribution in quality not only across plans, but within plans in terms of the quality of services they provide their beneficiaries it's true in the fee for service system as well.

Now you might well respond, well that's not a very good standard to which to compare the private plans given everything we know about how inadequate the fee for service system has been in qualitative terms in many communities in the United States all that time and that's a legitimate concern. Certainly when you put the actual performance versus the rhetoric of the private plans as opposed to the real world comparison. But the fact of the matter is, that if you set a

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low enough standard, the private sector can beat pretty comfortably [laughter] and consistently.

There have been throughout the history of prospective payment for managed care plans in the Medicare program. A series of marketing violations of one sort or another, these tend to go in cycles, they tend not to be constant or over time, basically every time there is an increase in the profitability of enrollment of Medicare beneficiaries because of a change in policy, you get a lot of plan activity, you get more violations reported. You then get some effort out of enforcement or at least oversight, some of that stuff is cut back and it's sort of the cyclical pattern of fraud and abuse in government programs of all sorts that is recurred there.

Favorable selection has been a constant in the history of the participation of private plans in the Medicare program since the mid '80s. But I happen to be very strongly of the belief that in fact well there have been various kinds of tricks and abuses and so forth on the part of the private plans in seeking only to enroll, the healthier beneficiaries that even if the behavior of the private plans were entirely exemplary and totally neutral relative to their enrollment activities, they would benefit from very substantial favorable selection.

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And I think that's - the evidence shows that's where most of it comes from, because when you think about particularly prior to the creation of abominations like the private fee for service plans when you were talking about Medicare private plans that were close paneled or had some restrictions on utilization, some part. And you think about what beneficiaries are going to be most likely to enroll in such plans. Answer, those who are least likely to have existing ties with doctors who aren't in the panel, i.e., those who aren't very sick, overlapping group, those who have recently relocated from the places they have lived historically to new communities, particularly in areas to which beneficiaries tend to retire where they don't know anybody and they don't know any doctors and they don't know anything about the healthcare system or people who don't go to the doctor very often for whom the lower premium or additional benefit weighs very heavily relative to the access issues, because access is not an issue for them.

In fact, we have a very well established pattern in the Medicare program over a large number of years now of people at or about retirement age moving to Florida, moving to Arizona, a few other kinds of places enrolling in Medicare managed care plans, remaining in those plans for some number of years are relatively low utilizers of service until they become seriously

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ill, then relocating back to the communities from which they had retired, disenrolling in the plans obviously and in general not reenrolling in managed care plans when they go back to their earlier communities.

The bottom line has been they was just really consistent throughout the '80s and into the mid '90s that just looking at the risk characteristics and medical care utilization characteristics of the Medicare beneficiaries who went into the managed care plans as opposed to those who stayed in the fee for service, they could be expected to use about 88 to 91 percent as much service, all other things being equal, dollar weighted as a fee for service beneficiaries, which meant if you were paying them in 95-percent in paying the plans of 95 percent of what you would have paid for the fee for service sector it was costing you a substantial amount of money, which is what Medicare was paying at the time.

It is important to remember and to understand because it critically effects the politics of all these issues as you know and increasingly effects the politics of all these issues as the plans and their advocates have become more sophisticated about this, that of the money that the government was overspending on the private plans not all of that was being pocketed by the plans. Some share of it has always gone in the form of extra benefits or reduced premiums to the

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beneficiaries. What share has differed by plan, by time and so on and so forth, but this is not just the private plans taking all this money, this is some of that money going directly to a small subset of beneficiaries at the expense of the federal treasury and to some extent at the expense of other - at the expense of other beneficiaries as well.

But that's a different political equation as we're increasingly learning than just overpaying the private vendors of one sort of another. It's also true that even controlling for the lower risk associated with their enrollees as best we can tell, the private plans did manage the utilization of, particularly the inpatient hospital services "more efficiently" than the fee for services system did.

On the other hand, controlling for everything else to the extent you can, HMO enrollees used fewer inpatient hospital base per thousand than fee for service enrollees did. But that the savings associated with that were not large enough to compensate for the additional administration of costs and related cost associated with the private plans. So that if you really seek to have the private plans compete on a level economic playing field with the fee for service system even though if you risk adjust for their favorable selection, even though they do use less services, they're still more expensive to provide the Medicare benefit package than the existing program.

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Nonetheless, in the Balanced Budget Act for a variety of ideological reasons, there were efforts to further expand the growth of private plans, but with a particular focus that you can all understand very much associated with the composition in the United States Senate with the recognition on the part of a growing number of members of the congress and the house of representatives in the senate, that Medicare beneficiaries enrolling in private plans are getting extra benefits and that there were no private plans in large parts of the country because, to overstate the situation somewhat, there were no people in those parts of the country [laughter] and it was therefore not economic to invest in the infrastructure associated with the private plan.

And so we have a number of adjustments and changes to the payment methodology for the private plans to A, make it more attractive for plans in general to participate in the program, but B, to tilt money, throw money in to rural communities to try to get the private plans to participate there. And in fact, it worked for awhile.

But the other thing the Balance Budget Act did was focused to a very large extent on payment for fee for service providers and for a whole variety of reasons, both the very capable professional experts at the congressional budget office and the very professional experts in the Office of the Actuary

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at the Health Care Financing Administration and OMB really misestimated the effects of the policy changes that they were going to make so that in fact, the actual costs to provider payments associated in the created in the Balance Budget Act came out to be about twice as large as everybody had predicted that they would be.

This, of course, created considerable unhappiness and discontent in the provider community. But the other ripple effect it had was that since the Medicare managed care rates were still tied to the Medicare fee for service rates, when the fee for service rate cost went down, the rates to the managed care plans went down.

In 1999 was actually the only year in the history of the Medicare program where total program expenditures were lower than the private the previous year direct effect of that so that all other things being equal, the rates to the managed care plans went up much more slowly in 2000 than they would have otherwise. And you can see this in the numbers in terms of the enrollment numbers.

Medicare enrollment and HMOs grew very rapidly throughout the 1990's. By 1997 at the time the Balance Budget Act was enacted, there were just under five million Medicare beneficiaries enrolled in HMOs. The Balance Budget Act at first had the desired effect, at least desired on the part of

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many of the people who worked on it, effect on private plan - participation of private plan enrollee. Over the next two years enrollment in private plans grew by two million people, almost 40 percent to just under seven million. Then the rate cuts started or the rate deceleration started to hit just about the time that cost in the private sector were growing very rapidly, the private sector managed care premiums were going very rapidly.

And by 2003, which was the troth in the post PBA period, Medicare managed care enrollment was down to just over five million again, a drop over the three years of about 25 percent. A lot of that was generated not by individuals responding but by plans pulling out of the business entirely or more likely out of particular counties, particular service areas, created an enormous stir, created a very substantial dislocation for a number of beneficiaries who had established patterns of care. Obviously, for those beneficiaries who have been benefiting from the extra benefits their plans, they were immediately worse off as a result of that. It created a political ripple effect, part of which I think are still with us in terms of the way the congress views a lot of these issues.

Interestingly enough, this sort of cycle that occurred starting in '97 through about 2003 was almost perfectly

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mirrored an identical cycle that happened in the late '80s again after the initial influx of managed care plans in the Medicare program and then the first series of cutbacks in their payment rates just at a higher level, there is at least two histories and if we're successful in the legislature this year, there will soon be three periods in which periods of very rapid growth in Medicare private plan enrollment were followed by periods of relatively rapid falloff in that.

And that's a cycle I think that is entirely predictable and one place where in fact there is a theoretical underpinning to think about in terms of the relationship between the public and private sectors because one of the things that is characteristic of private markets, particularly private for profit markets is that capital flows in and out of them relatively rapidly. And if the rate of return on invested capital in running an HMO in Peoria is not as great as the rate of return on buying Japanese derivatives then in fact people are going to disinvest in the managed care plan in Illinois and put it in some other investment. And that's the way the private sector is supposed to work.

I've actually argued elsewhere in other settings that one of the benefits of non-profit ownership in the healthcare system is precisely how inertial not for profit institutions tend to be in large part because of the different structure of

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capital and where they get it from and so on and so forth. And so here is one I think theoretically, if you want to do something fact, particularly in terms of attracting significant investment into something, you need the private sector to do it, at least the way we generally tend to do things in this country short of a Manhattan Project or something like that. But if you do that, you continuously run the risk that the disinvestment will be symmetrical with the investment.

In fact, the private nursing home industry in this country largely sprung up in the mid '50s after public policy makers in a variety of places decided we need to have a lot of nursing homes and the not for profit sector and the public sector, which dominated both acute and long term care, that purely really weren't interested and so they finally began to think about explicit incentives for private investment to get all of those facilities built. And then a lot of those builders left 10 of 15 years later causing all sorts of predictable kinds of problems.

In the interest of time, we then get sort of the high point of privatization in the famed Medicare Modernization Act of 2003. A lot of the issues associated with that were discussed quite well in the previous panel, but, one of the things I want to suggest is that if you really believed in the inherent superiority of private market competition to maximize

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consumer choice and produce the best possible benefits for the dollar in the design of a new insurance program, you wouldn't have designed anything like Part D.

This was the triumph to a conservative stand of both ideology and political influence over any sort of rational structure. What we have - many of the problems that people have encountered in dealing with Part D in terms of there being too many plans certainly in terms, I mean, the one thing that I think everybody in the theoretic literature would say, if you want to get real private competition that's going to benefit consumers and that's going to drive down prices in an insurance kind of market or the other kind of purchasing of a complex product, the most important thing you have to have is some degree of standardization in the nature of the benefits and total transparency in the information of stuff that isn't fully standardized. That was rejected explicitly by the designers of those programs.

It would have been very useful as often happens in other efforts to create privatization to have a public sector, what we used to call yardstick as the target against which private plans could compete in terms of customer satisfaction and price. And in addition of which, the kind of information infrastructure you need for choice in this sort of market tends

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not to appear spontaneously and actually the creation of it is not something governments are particularly good at.

So, what has resulted has been an excessively expensive plan, just how much this design is costing tax payers and beneficiaries over a more efficient design is something I think that remains to be identified, but it's clearly a quite a lot of money. There's an enormous amount of unmeasured non-market cost in the hassle difficulty time and effort that beneficiaries and their families and their advocates have to spend trying to make their way through this maze of one sort or another, which tends not to get included in the calculate.

And the result is a significant transfer of wealth, of course, from the government and beneficiaries to the private plans and to some extent I suspect to the more clever manufacturers of one sort or another. To me the most bothersome thing about that is that the result is that the donut hole is too big. I mean, if you had the same amount of government dollars, same amount of benefit premiums and a more efficiently run plan, you could provide a more generous benefit. I mean that's the simple arithmetic associated with that. And in many ways, through the average middle class beneficiary the major problem with Part D notwithstanding all the hassles associated with picking a plan and getting individual coverage and all that kind of stuff, which are all

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very real and all very serious, the major problem is the coverage isn't good enough. And if you had a more efficient program design, you could provide better coverage.

Now the other thing I will say is in the period around and after the enactment of Part D when I would yell and scream at people about it, they would say well, at least we got good coverage for low income beneficiaries. And I was skeptical to the argument at the time, but in fact I would argue that the biggest failure in the design administration of Part D has been the scandalously low enrollment rates of the low income - for people entitled to low income supplements and that's been a government responsibility not a private sector responsibility.

Now, and I think we have to be very open and explicit about that. Now I think the major reason the government has done such a bad job at enrolling the low income beneficiaries is because the congress, again, contrary to all evidence and rationality imposed a asset test of a kind and a degree of specificity that is, and I think some people probably knew what they were doing, looks like it were designed to keep people from enrolling or being eligible for the benefit and probably distorted all the estimates of the number of people who were in fact eligible for it.

And so it can't be the failure to enroll - to do better on enrollment of the low income. It's not entirely

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attributable to ineptitude on the part of the government agencies, although to a considerable extent it is as well. But again, I think we have to be open about that.

Again, in the interest of time because the previous panel talked about it generally, there is no intellectually defensible rationale for the extent of the overpayment of the Medicare Advantage plans that exist. The arguments that are coming out of the health insurance industry for why they shouldn't do it are increasingly sort of strained and I think even the spokespeople for the industry are having increasingly difficult in keeping a straight face in repeating some of them.

But the political argument, the political reality is there are a lot of folks in South Dakota and Montana and a few other places who are getting extra benefits from the private fee for service plans, which do nothing else other than take a 20 percent premium out of the federal government, split it up between themselves and the beneficiaries. And it is a really a very efficient earmarking system in a variety of ways and therefore hard to undo in a variety of ways.

Interestingly enough, the most recent numbers I have on private enrollment in Medicare Advantage plans from Tricia and her colleagues is that we're about 8.7, 8.8 million at the moment in Medicare Advantage plans, about of whom 1.5 million are in private fee for service plans. If you do the arithmetic

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that means we're almost exactly back 1999 plus the private fee for service plans. So how strong this trend really is, I'm, I guess increase cynicism I very much understand conceptually the threat that continued overpayment to these plans poses to the long term well being of Medicare and I'll say a little bit more about that in a moment.

On the other hand, it looks a lot like the previous cycles and certainly those of us whose live in a world having our assets no longer in defined benefit but defined contribution plans and actually have to pay attention to the markets, go against the cyclicalality of most economic phenomena at our own peril. This may well be another case of that.

Alright. So having said of that, given this record why do we have this sort of rhetorical conversation we have and why does the congress persist and the executive branch and abominations like the Medicare Modernization Act. And I think there are four reasons for that and I think they're interrelated. And I think we really in dealing with these questions have to worry not only about sort of the intrinsic measures of public versus private sector but about where these arguments come from or where these efforts come from and what we're going to do about them.

And as I said, there are four, that's sort of arbitrary the way I've divided them because I think they are

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interrelated. There is a very, very strong tradition in this country that historians have talked about and so forth of skepticism or distrust of government that goes back to colonial times and so forth and does distinguish American political culture in many ways from that of most other civilized countries. And it can go back to explanations such as this country was founded largely by people who wanted to get away from governments of one sort or another. I think that's true and I think that is a very important part of popular culture.

At the same time, however, there is a theory that people have been bold enough to articulate, people like Grover Norquist and others from time to time and really originated not in dealing with American political culture, but really originated with the right wing in Britain in the 1970's and was most explicitly announced by the Thatcher Government. And that was a theory which again, is not consistent I think largely with the historical facts, that the real problem with government entitlement programs with the welfare state was that they constituted a kind of bribe to the electorate on the part of the political parties in power and that as long as those programs were in tact and people continued to think positive about them and support them, they would support and think positively of the political parties that have brought them to that.

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And it is true that all of the things being equal, the average American trust democrats more than republicans on issues of Medicare and Social Security because people have some rough concept that these were programs that were originally developed and enacted by democrats over the opposition of republicans. And therefore, this sort of Thatcher strategy as it's been recreated in the United States is to begin to dismantle the entitlement programs not only because people don't like entitlement programs as a way, but because that is the part of the framework or the precondition for fundamentally shifting the balance of partisan power in the population and therefore in the elections so that the rhetoric and it's sort of very clear in some of the analysis of the political consultants and so on and so forth around many of these issue and I think including the way the executive branch and others try to characterize the SCHIP legislation, the code words are when people say the government is bad and the private sector is good, what they are - the message they are clearly seeking to convey with some degree of success to at least some audience is that democrats are bad and republicans are good. And that's clearly been a part of an explicit strategy.

Now that ties in with an even more cynical and therefore more accurate and comprehensive view of some of these things, which is when you have a program administered by

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government agencies, they don't generate any campaign contributions out of the payments they make. And one of the things that contracting out of public services does is create a cadre of organizations that are indebted to the government and are prepared to invest in continued support by the government by giving back to the folks who got them the money in the first place.

So I think it's important not to be as partisan here because on a variety of Medicare issues over time, I think democrats have been as likely to practice this kind of politics as republicans have been. But there was a very clear connection certainly when I was in Washington in the 1990s after, especially after the 1994 congressional elections between the so called K Street Project being much more systematic about raising money from people who had a stake in public policy to support campaign contributions and legislative provisions associated with the Medicare program.

And if you go through - some day somebody will do this systematically the way they do with works in important literature, if you go through the Medicare Modernization Act with a fine tooth comb it's sort of a users guide to interested parties and campaign contributions in the health sector in the United States, more in the miscellaneous provisions than in some of the Part D stuff and everything, but it's really quite

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fascinating. Those in the know can point to you provision by provision and name either the lobbyist or the provider associated with them of some sort or another. And this of course becomes a very healthy self reinforcing cycle over a period of years that it's hard interfere with.

A third and to some extent more legitimate motivation here and it's really again important to understand, advocates to understand and figure out how to deal with. And I used to hear this a lot from sort of the democratic leadership council types, but it ends up tying back into these other issues is that one advantage from the viewpoint of an elected official for turning over administration, certainly a public health insurance programs to the private sector is that it diffuses accountability and takes away visibility of making hard decisions from the public official. So if it's a question of whether we're going to cover this drug or service the ones who are another or not covering a particular beneficiary or cutting payments to providers, it is much more convenient for politicians to pass the buck and to delegate responsibility for that to the private plans. And that was clear by the way, when the Clinton Administration in '98 and 99 proposed a Medicare drug benefit, they were going to have it administered through private pharmacy benefit management plans precisely because they didn't want to get into the issue of formula construction

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and they didn't want to take on the politics of having to directly be responsible for formularies. And so they would pass the buck.

And in theory, it's kind of nice if it works that you could pit the plans and I've heard some of this rhetoric against the individual providers of service on issues of fees and issues of quality. So if the plans had the appropriate incentives and the appropriate skills, they would enforce a greater degree of discipline both economic and qualitative on the healthcare providers than the government is able to get away with in the current political environment. That's a nice kind of theory.

What tends to happen in the real world, however, is that private sector folks tend to work with one another very well and the plans and the providers tend to gang up together and conspire together to shift a responsibility either to the beneficiaries or to the treasury and that's a large part of the economic history of the Medicare Advantage program instead of causing the plans to negotiate more harder with the providers of service, in fact it's gotten the plans and providers negotiating together with the congress to give them all more money of one kind or another.

And finally, as Marilyn and the other panelists discussed this morning, there's no question that some of the

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more visionary or systematic thinkers, I associate this particularly with Congressman Thomas, have a long term vision that and an understanding that over time, and again, back to those projections, if you are going to deal with the long term financial imbalance in the Medicare program, which is real because we haven't figured out how to control healthcare costs at the moment, there are really only in the aggregate level, if you don't control healthcare costs in general, there are really only two choices. You can put more money into the program, which in fact would still leave Americans much less heavily taxed than other people, but that's a whole 'nother question or you can shift more of the cost to the beneficiaries and their families.

And the problem is politically it always appeared to be very difficult to get away with shifting a lot more cost in the short run to beneficiaries and the families. So the strategy that was explicitly adopted to do that was to begin to convert Medicare over time from a defined benefit to a defined contribution program by encouraging the gradual shifting of the provision of the insurance benefit to private plans and then monkeying with the way private plans were paid so that over time the government could cap its liability and any increase in cost over what the governments pay would have to be conformed by the beneficiaries.

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And that's obviously the greatest long term danger associated with privatization in the Medicare program, but I would suggest that it's entirely consistent with the rationales and the arguments to the other reasons that I've given you as well, which is one of the reasons it makes for such a powerful political formula.

Having said all that and having began to invade lunchtime as well, how do we conclude and where do we get to this? I, without going into a long complicated decision, the lesson to me is that some of the dysfunctions in the Medicare system or the Medicare policy are increasingly clearly attributable in a causal way to some of the dysfunctions and changes in our political system more broadly.

And I really am convinced, although this makes the task for advocates in the long term all the more difficult and all the more challenging. If we're going to fix these problems over time, if we're going to really get the Medicare system operating the way it ought to be operating, if we're going to preserve Social Security the way it ought to be operating over time, we can't confine the discussion and the debate within the confines of those programs. We really have to talk about reforming the underlying political system as well.

To my mind, that has something to do with the role of money and campaigns, it has a lot to do with who participates

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in the political process and who doesn't in figuring out how to get the folks who don't into a larger kind of discussion. In the short term, it's very useful to win elections and then to hold the winners feet to the fire. But in the longer term, I think in order to preserve Medicare we're going to have to reform the American political system as well. Thank you very much. [Applause]. Do you want to take discussions to the panel or do you want to have a few minutes?

**JUDITH STEIN:** We could [inaudible]. Excuse me. I do want to say one of the things that the brilliance of your talk and in particular the way you summed up things I think, for those of you who wonder why we're spending so much time on Medicare, because it's not the middle name in everybody's - every organization, but it's - in addition to it's so important for older people and so important for the U.S.

The current privatization and movement that Dr. Vladeck just described is I think really endemic of the way the system has been working over the last decade or so. And what - as he says, though perhaps the president, as I think it was Tricia indicated said, we can't predict the future because it hasn't happened yet, but it is quite possibly the way we will be going in a number of other areas as well if we don't think and take the challenge, not just to handle the Medicare, Social Security

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and other issues facing our clientele, but also the entire American election system.

So, Bruce's left us with that challenge as well. And some of my colleagues have already said, of course we have not got the funding of resources to do that, but we'll just take on the election system as well [laughter]. So it is - is there one or two questions for Dr. Vladeck and then we'll break for lunch? Yes.

**MALE SPEAKER:** [Inaudible]. What were things that really troubled you [inaudible] the provision [inaudible]? And [inaudible] and probably everybody in the room of being [inaudible]. But one of the things that was always [interposing] -

**JUDITH STEIN:** Repeat the question if you would.

**BRUCE VLADECK:** Alright.

**MALE SPEAKER:** - these [inaudible] again, there are people where [inaudible] commercial people and [inaudible]?

**BRUCE VLADECK:** The question was, Judy suggested with our acoustic issues I repeat it and to summarize very quickly that one of the things that bothered - it's hard to get a top ten list, [laughter] most about the MMA was the whole special needs plans idea because it meant sort of segregating a class of beneficiaries when in fact the private plans up to then had

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not particularly wanted to know what was happening. There are people in this room who probably know better than I do.

My impression is that they're actually - CMS has contracted for quite a number of these plans, but they don't have a whole lot of enrollees with a few exceptions. And frankly, that's because most of them are really designed for the dual eligibles and the states are real weary of this having been sort of screwed on the drug benefit and some of the other things and knowing a whole lot more about what it takes to manage in the decapitated way, very highly disabled people or people with very special healthcare needs. The states have been very cautious about moving forward with that.

So as I say, CMS has been pushing them, some of the private firms have been interested in them, but they're moving ahead very slowly by and large, so. Any one else?

**JUDITH STEIN:** Is there another question?

**BRUCE VLADECK:** Time for one.

**JUDITH STEIN:** Okay. Then thank you so very much and Dr. Vladeck [applause] will be with us. Bruce will be with us in the session following lunch. I would like to ask you all to move towards the - my right your left and we'll light the cake sing happy birthday before lunch so we can cut the cake and you can have desert. That's the reasoning for it.

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And if the staffs of the two organizations would move towards the screen we'll just do this and have a little bit of a party and we'll have a good lunch. And we will start the program at one o'clock. Thank you.

[END RECORDING]