

## **Outlook On Health Spending**

**February 11, 2004**

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**ROB CUNNINGHAM:** Good morning everyone. My name is Rob Cunningham. I'm from *Health Affairs* and I'm just here to welcome you and to present the presenter of the panel and to thank the Kaiser Family Foundation for hosting this forum for these findings. A couple of observations from the editor and publisher's viewpoint about this particular paper; one is that the reason there's people here this morning, the quality of the work that the actuary's office puts out, the reliability and disinterestedness of these projections is something that everybody has come to rely on. One piece of evidence to that effect, is that when we published these papers last year on the Internet, since then, in the past year there has been thirty thousand downloads of the previous paper by these authors. That's one way of putting it. The only other paper with numbers in it that's drawn that much attention is Drew's, so he'll be able to present this business in an interesting fashion.

The other editorial issue that arose in publishing this paper was that the paper was under review at the time that the Medicare bill passed and this presented a challenge to all of us. We naturally wanted to encourage the authors to do as much as they could to fold these breaking developments into their revision and they wisely resisted our pressure to do so, knowing that you can't do good work on the fly. But what they have done and what I think you'll find interesting is address

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as much as they could, the relationship between the projections that are fully worked out and the kinds of assumptions that will have to be addressed in making revised projections.

It gives you an idea of the care with which they've thought through the projections and it also gets you kind of inside the process of working through assumptions and so on. So as editors, we learned from working with the actuary's office on this paper and I think you can learn from that process too. Drew is going to take it from here.

**DREW ALTMAN:** Thank you, Rob. It's a little weird to hear someone else welcome you to our building. I also want to welcome you to the Barbara Jordan Conference Center. Good to see you all; many familiar faces. And the last time I wore one of these mic's, I actually charged into the men's room in this building with the mic on, only to be rescued by one David Kessler. It's a Washington story that should never be told so I'm hoping there are no reporters here today and I'm hoping for a smoother performance here this morning.

I think that the *Health Affair's* web exclusives are a great way to bring critical studies and information to the health policy community in Washington quickly, and as you may have noticed, that's exactly the business that we're in at the Kaiser Family Foundation. So it was just a natural route for us to join forces and launch this briefing series using our Barbara Jordan Conference Center to bring the authors of some

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of the most important web exclusives and commentators with diverse points of view to a Washington Health Policy audience, but also through kaisernetwork.org, which is broadcasting this event to bring this briefing and these findings and this discussion to the Health Policy junkies; to the Health Policy community all across the country, which we're very excited about.

This is the first in this new briefing series. We've got an important web exclusive. We chose to start with this study because it is an important study. To begin with, because the CMS projections of what the future of health spending and healthcare costs might look like is really one of the very few studies, I'd say it's just a handful of studies, and I'm sure Dan and Henry would agree that all of us masochists in health policy look forward to anxiously every year, along with the other important CMS study that looks at the year just past, which is also published in *Health Affairs*. And so we have the lead author, Steve Heffler, who is astonishingly young to be projecting the future, here with us today, who is the Deputy Director of the Health Statistics Group at CMS.

As many of you know, we sent out an updating e-mail alert yesterday. We had hoped to have Rick Foster with us today, who is the Chief Actuary, but we received word yesterday that he would not be able to make it. We have been assured by CMS that Steve will handle all questions about anything,

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including Iraq or, no, I'm just kidding about Iraq, or anything else you want to ask him. Our commentators today could not, by any stretch of the imagination be better. We have Dan Crippen here today, who in addition to many other illustrious assignments, is of course the former CEO, Director and we have **HENRY AARON**, Senior Fellow at Brookings. Henry was a towering figure in this field when I entered this field, and he's still towering.

I'm sure that everybody will leave this briefing, I already know this, with at least 2 numbers in your head; you know, that's 3.4 trillion dollars and 18.4 percent of GNP in 2013, but we do want to go deeper than that here today. That's the reason that we are having a briefing and so Dan and Henry are here to help us with that.

As Rob alluded to, I've written a lot about this issue and I care a lot about this issue and I've talked a lot about this issue, but I'm here today as a moderator. I'm going to try as best I can to keep my own opinions in check as much as I can. But before we get started with the presentation, I thought I'd take just a minute or two and frame a few questions. For people to keep in mind, I do want to say that the commentators should not in any way feel bound by the questions I'm framing here. But first of all, we know with certainty that these projections are not going to prove exactly right. They're not going to be precisely right because they are projections and

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they're never exactly right to the number. But one question just to keep in mind is, are they substantially right? And the projection, kind of in broad terms is that healthcare costs are not going to rise as fast as they did in the horrible late '80's, but they're also not going to rise as slowly or more slowly as they did in the mid '90's.

And I thought I'd show you just a visual to try and give you a picture you can keep in your head. Sean, if we could get it up here. There we go. I'm looking at the screen. This is Outlook for Health Spending. This is an adaptation of a chart I published in that *Health Affairs* web exclusive I did with Larry Levin some time ago in a short article called the "Sad History of Healthcare Cost Containment." As told in one chart, and as you can see from the title, what it does is it measures the percent change in per capita private health spending adjusted for inflation and then, all we did for today was try and add the CMS projection. That's that dotted line at the end to the chart. So as you can see, CMS is projecting a return. Just to think about this in broad historical context to what has been that flat line in the middle about the average rate of growth in per capita health spending, 3.6 percent above inflation. And you can also see that the history at least suggests that, even if the projection for 2013 is exactly on the mark, there could be some ups and downs between now and then. So I do think that one question to keep in mind here today is, do these

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projections seem right or do they feel optimistic to some of you or to some of our commentators?

And of course, even if they are right it is still an increase, a real increase above inflation of 3.6 percent, which does raise the time-honored question I've been dealing with since I've been in this field: is this sustainable or is it not sustainable? Dr. Altman, does something have to give if we reach more than 18 percent of GDP or no, will we instead just pay the bill because the American people want the health services? What are the implications for our economy for what people pay out of pocket, certainly for wages?

I think importantly for our ability to address other big-ticket health problems, like the problem of the uninsured and what does it all mean for the politics of healthcare? Because we all know that this issue cost is what is driving our issue back to the top of the political agenda. So that's one question to keep in mind. Another one is, just a broad question is, is there anything on the horizon that could significantly change the upward trajectory forecasted here by Steve and his colleagues? Now my view of that, and it is only my view is no. I mean my view of where we are on this issue is that we're kind of stuck in neutral on healthcare costs. We're not willing as a country to return to the tougher managed care of the mid '90's, but we're also not willing to regulate as the other developed nations do. So we're kind of stuck between paradigms with a

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bunch of halfway measures with names like "chronic disease management" and "consumer driven healthcare" and "shifting costs to working people", all of which might or might not have other positive effects, but in the broad scheme of things, will have an impact on the upward trend in healthcare spending. Only I think that the margin, but that's just my view and I'm sure others will have theirs.

The question to keep in mind is, is there anything anyone can think of on the horizon that might dramatically change this? And finally, there was an interesting finding in this study to me that really caught my attention and kind of befuddled me a little bit that I think is worth coming back to, and that is this: the studies show that out-of-pocket spending as a percentage of disposable income, which I think, Steve, is a very fair measure of how this impacts people, will rise from 2.7 percent in 2002 to 3.1 percent in 2013, which is obviously higher than it is now but a little lower than where it was in the last healthcare cost crisis of the late '80's and early '90's.

Now I should mention, as Steve will, that the way CMS does this, which is entirely legitimate; their measure of out-of-pocket spending as a percentage of disposable income does not include what people pay for premiums. They do count it. They just count it in a different way so the number, as people perceive it might be a little higher, but it's not going to be

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dramatically higher. But here's what I find interesting about that. There is absolutely no question that worries about healthcare costs is what has propelled healthcare to the front of the political agenda again. Every survey we do shows that, and it shows that very clearly, and there's also no question that out-of-pocket costs are going up as we see in our annual employer's survey. But on the other hand, 3.1 percent is 3.1 percent and housing is 14 percent, I think, and food is about 14 percent. So it kind of does raise the question in an interesting way of why really are people so upset? Because they actually are so upset. And I have my own answers to that question, but I will certainly not give them now. I just think it's a useful question to maybe come back to later on.

Okay. So that was just an attempt to get us started. Let's first hear from Steve who will present the findings in summary form and we'll move on to our distinguished panel and then we'll open it up so that you can all get involved. And I would encourage Steve also, as he chooses to call on his colleagues from CMS who are here today, who also have been part of this.

**STEPHEN HEFFLER:** Great. Thank you, Drew, for the introduction and to Rob for the nice words about the article and about the process for getting this year's article published in a timely manner even though there was significant legislation that passed right at the very, very end of our work

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at CMS in producing this set of projections.

I wanted to thank both the Kaiser Family Foundation and *Health Affairs* for inviting us to speak today at this session. We were, last year was our first year of doing this article as a web exclusive and we really weren't sure what we were getting into and we were very happy with the dissemination of the information, the reaction that we've gotten for publishing as a web exclusive. And we're excited to do it again this year. It also helped us get our information out much quicker than we had in the past and so that's a very positive thing. So, thank you for putting this briefing on and inviting us to speak, and hopefully, everyone here finds this interesting.

I also wanted to sort of say a thank you to my colleagues who worked with me on this and, in fact, I'm here speaking, but as you all know, you never do anything by yourself, and in fact, it's the person that speaks that usually did the least amount of work and that is the case here as well. So, all the coauthors are here; Sheila Smith, Chris Troofer, Mark Zeza, Sean Keyhan, and Kent Clemons and I may indeed call on them to answer any detailed and hard questions that come up. I'll take the easy ones.

A little bit about the projections before I get into the current trends, just to give you a little bit of background on our basis for making these projections and some of the assumptions that we used in the projections. Our last year of

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historical data is 2002. That is the most recent National Health expenditure data that has been produced and released and, as was mentioned earlier, that was released in an article in the January/February issue of *Health Affairs*. Those estimates are also produced in our office, the Office of Actuary at CMS.

The economic and the demographic assumptions that are the basis for these projections, as well as the projections for the public sectors, and specifically Medicare and Medicaid are based off of the 2003 Medicare Trustee's Report, which was released last March, so March of 2003. That's sort of out of date. At some point, there will be a new trustee's report coming out in a month. So what we generally do is, we update the information in that trustee's report, both the economic assumptions, as well as some of the public spending assumptions for data that's available when we're doing our projections. This year that meant we had data through November of 2003 that we incorporated into the set of projections. It also meant, since we always do a current law projection, that we were doing the projection "Current Law" as of November in 2003, which as was mentioned previously is prior to the most recent Medicare legislation and therefore this set of projections does not include any quantitative estimates of the impact of that legislation.

A little later on in the talk I'm going to mention a

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few of the qualitative impacts that we think are likely to occur because of the legislation. But again, there is not any specific estimates that we have. The article gets into a little more detail than I will here in the presentation about some of those effects, as well. So being that the effect of the recent legislation is not in these projections, what can these projections be useful for? Well, the way we look at it is at least in the near term, we always laugh when we talk about near term and far term, because near term for us is 2, 3, 4 years out and for a lot of people it's 6 months out is the near term. But at least over the next few years, 2003, 2004, 2005, we really think that this projection can serve as a good indicator of what our expectations are for trends by pair and in aggregate for health spending.

After 2005, so 2006 and beyond when the major parts of the Medicare Modernization Act really come into play, we feel that these projections can serve as a baseline for sort of determining the impact of that legislation, once we update the projections to include the impact of the legislation and we do plan to update these projections at the earliest opportunity and build those effects in.

So, given that, let's go ahead and turn to the actual trends and the findings of the article and the projection. And first, we're going to focus on the percent change and overall national health spending, as well as the share of health

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spending of GDP, which Drew has mentioned a few of the numbers from the article. If we look on this first slide and focus on the yellow line and the line with the circles, as the chart indicates we do project that health spending growth will have peaked in 2002 at 9.3 percent and then slow to 7.8 percent in 2003 and then again, slightly to 7.2 percent in 2004. There are two major reasons for the slowdown in the near term. The first is that we do project that spending for Medicare and Medicaid services, the growth in those two programs will slow relatively significantly in 2003. And again, for the Medicare this is prior to the legislation and the impact that that would have. The slowdown in Medicare is due in large part to the expiration of some of the legislative givebacks that occurred with the legislation in 1999 and 2000. Many of those provisions expired beginning at fiscal year 2003, as well as a reduction in outlier payments for inpatient hospital care based on some recent CMS policy changes and regulations that have been issued regarding that.

For Medicaid, we project that growth will slow from 11.7 percent in 2002 down to 7.5 percent in 2003. Much of this slowdown is due to state's decisions to slow spending growth in the face of their fiscal problems, as well as what we project to be a slow down in the enrollment growth number of folks joining the Medicaid roles. Growth was 5.9 percent, enrollment growth in 2002. We have that dropping about 2 percentage points

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in 2003. So slowing public sector spending growth is one of the major reasons that the overall trend looks like it does.

There is also what we project to be a slow down in private health insurance premium growth and the next slide I'm going to get into that in much more detail, so I won't discuss that here. As a share of gross domestic product in our nation's resources, which is the orange line and is highlighted by the diamonds on the chart, we do project that after representing 14.9 percent of GDP in 2002, that healthcare spending will account for 15.3 percent of GDP in 2003. Should this occur, this would mark the fifth consecutive year that health would increase as a share of GDP and this would follow a period between 1992 and 1998 when health spending was, essentially flat as a share of GDP. Over the entire projection period we project that by 2013 health spending will reach 18.4 percent of GDP and that each year during the projection period that health-spending growth will outpace GDP growth. Again, let me emphasize prior to the Medicare Modernization Act effects being built in.

Relative to where we were last year and what our expectations were when we released this set of projections last February, our trend that we projected is still similar to what we had projected last year. We did think that 2003 would really mark kind of the first period in which we had seen significant deceleration in spending and it would continue through 2005.

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Last year we projected that health-spending growth would be essentially flat in 2002 and as you can see, it came in a little bit higher than it had grown in 2001. Given that it was faster than we had expected for 2002 and that GDP growth was actually a little lower than we had expected for 2002, the health share of GDP in 2002, which was 14.9 was a little bit higher than we were projecting last year. That combined with our trend currently which is slightly higher as far as growth goes on average over the projection period now than we had last year, means that by 2012, which is a comparison point to last year's projection, we're about four tenths higher as a share of GDP this year than we were last year. We were at 17.7 for 2012 and we're currently at 18.1 percent.

Okay. So moving to what we expect for private health insurance and specifically talking about private health insurance premiums and the growth in those premiums. Definitional issue first. Drew mentioned sort of how we define out-of-pocket spending versus private health insurance spending, so let me explain a little bit about premiums and what we mean by private health insurance premiums. These are all premiums paid for private health insurance, so it's both employer and employee share, any private health insurance that the elderly purchases and any other forms of private health insurance that are purchased are all grouped into one broad category defined as "Private Health Insurance". We call that

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"Private Health Insurance Premiums" because it represents the total amount of money that is spent for private health insurance and we also, actually this chart is per enrollee, and so we then divide that by enrollment growth in private health insurance to come out with private health insurance per enrollee percent changes. As the chart shows, growth in 2001 and 2002 in private health insurance was greater than 10 percent, double-digit growth. The first time that had occurred since 1990. And we project that 2003 will mark the third year in a row in which premium growth will be in the double-digit range. We do, however, have this growth decelerating slightly. Growth was 11.4 percent in 2002 per enrollee. We have that decelerating to 10.4 percent in 2003 and then decelerating more significantly in 2004 and 2005.

There are three major reasons for the projected slowdown in private health insurance premium growth over the next few years. First, we do project a medical price growth as measured by, what we call our personal healthcare deflator, which is the deflator used to measure prices in the national health accounts and is an essentially a weighted average of price changes for different medical services and products. We do project that medical price inflation growth will slow in 2003. This seems to be supported by a lot of the data that's currently available for 2003, so if we're going to be exactly right on one part of it, hopefully, we're pretty close on this,

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since we had a lot of the 2003 data when we made these projections. We have the growth slowing slightly from 3.9 percent in 2002 to 3.5 percent in 2003. Again, this is medical prices. And really, this appears to be sort of in response to wage pressure easing in the healthcare sector after what was a sort of a run up in wage growth in 2001 and 2002, driving in large part by expected shortages in specific healthcare occupations, like nurses.

The second major reason that we project health insurance premiums to slow in the near term, is we do expect a slight slow down in the demand for medical service and this is driven in large part by one of the major factors in our models, which is sort of overall economic conditions and specifically income growth. Health cycles tend to lag economic cycles, so this has been essentially true in every cycle over the history where there is a slowdown in overall economic and wage growth and then thereafter 2 to 4 years later we start to see slow downs in health spending growth. We expect the same here, so the slowdown that we saw in income growth and in economic growth in 2001 will start to play its way through the healthcare sector beginning in 2003 through the end of 2003 and into 2004. We're seeing this both in the hospital sector and I'll talk more specifically about that next, as well as with prescription drugs.

And the third, then, major reason why we project this

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sort of near term slowdown in private health insurance premiums is we do as we had last year, expect that the underwriting cycle will turn in 2004. And this would follow 5 consecutive years in which health insurance premium growth outpaced the actual benefit with the cost growth or for private health insurance and the underwriting cycle there being sort of a cycle that represents how premium growth relates to underlying benefit growth. The cycle tended to be shorter in historical periods and a little more extreme. Our projection has the cycle lengthened a little more and not as significant as we have seen in the history. So given those trends in private health insurance, there's sort of a natural implication of, as consumers of healthcare we see the cost in what we pay for insurance, but we also see those costs in what we pay out of pocket and as Drew mentioned, the way we define out of pocket in the National Health accounts is to be specific that out-of-pocket spending is really spending that is made sort of at the point of purchase or through any forms of deductibles, coinsurance, co pays, or any spending that's made by people without insurance that is made directly out of pocket. That is what we define as out-of-pocket spending, and what we've seen is actually the opposite trend in growth rates that we've seen for private health insurance premiums.

We are projecting that out-of-pocket spending growth will accelerate over the next few years, while we're seeing

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that we project the private health insurance premium growth will slow. And a large reason that we think that this is occurring is because of the impacts the tiered benefit structures that we see for prescription drugs, as well as efforts, especially recently, to buy down premiums and shift more of the cost to the point of purchase and to consumers are starting to take hold and they're starting to effect the growth rates and out-of-pocket spending. However, even though that growth rate is accelerating, it's still growing in our projection period, at least in the near term, less fast than private health insurance growth. It's not double-digit growth in out-of-pocket spending.

Therefore, the share of overall health spending that out-of-pocket spending represents continues to fall. It has in the recent period. We do project a slight fall in that share over the next few years and that masks an important trend and this is the information that Drew had presented earlier, which is we get a lot of questions and we always have a difficult time explaining why the share of that out-of-pocket spending represents of total health spending can be dropping when everyone says, "But I'm paying more. My co pays are going up. My deductibles are going up. I am paying more out-of-pocket" and really, as I mentioned that is occurring, it's just the growth rate isn't keeping up with private health insurance premiums. But what the growth rate of that out-of-pocket

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spending is representing is a faster growth than we're seeing in incomes. And we do project that over the projection period that the out-of-pocket spending growth will far outpace the income growth. Drew mentioned the figures were currently at 2.7 percent in 2002. We project that getting to 3.1 percent by 2013. That would be near the most recent peak, which was in 1990. That was only 3.2 percent. And would be near, and then between 1974 and 1990 the share wasn't that high and so we'd be approaching the share prior to 1974 when we were a very different healthcare environment where much more of the care was pay out-of-pocket and less by private health insurance. So we do think that is a significant finding from the projections and we do feel that the trends in out-of-pocket over the next decade or so are going to be important to keep an eye on.

Okay. So to focus a little on some sectors and get into a little more detail as opposed to aggregate trends, I'm going to talk about 2 specific sectors here and there's reasons for these. One's the biggest and one's the fastest growing and so they always make good talking points.

First, to talk about hospital spending growth and the trends there. Hospital spending by far is the largest piece of the healthcare sector. It's about 31 percent in 2002. And the trends in hospital spending have actually been a major reason that overall health spending growth has accelerated in the past few years. You can see here growth sort of troughed at 3

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percent in 1998 and was nearly 10 percent. It was nine and a half percent in 2002. A significant acceleration in spending on hospital services. We feel that this sort of upturn in this growth rate is pretty much a cyclical pattern and we do expect that the growth rate will subside in the near term of the projection period as you can see from the chart there.

We do have a somewhat significant deceleration projected for 2003. Most of this slowdown is actually because of what's occurring on the public side and I mentioned a couple of those things earlier with Medicare and what's going on with Medicaid and the slowdown projected for those two public programs in 2003. We are projecting a modest slowdown in spending for hospital services for private payers and this seems to be supported by some of the price data, as well as some of the labor indicator data that we have for 2003.

Hospital prices are projected to slow from about 5 percent in 2002 down to 4.1 percent in 2003, so a significant price drop, as far as the growth rate goes, for hospital prices. And that really kind of again reflects sort of the easing of some of the wage pressures we saw in the 2001 and 2002 period. We've also seen slower growth in employment in hospitals, as well as some anecdotal reports of possibly starting to see some signs of slowing trends in sort of the demand for hospital services. So those factors are really what influenced our near term projection and slowdown in hospital

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spending. Over the longer term you can see hospital spending growth is about 6 percent in this projection. Overall health-spending growth is a little over 7. So as a share of health spending, we do project that hospital spending will continue to fall, which has been the historical pattern for quite a period of time. And really that's driven by our assumption that technological change will sort of increasingly allow for care to take place in settings outside of the inpatient setting and we document that some in the article and the reasons why for that.

So, that's kind of a quick rundown on hospital spending. To talk about prescription drug spending, let me emphasize again prior to the Medicare Modernization Act, since this is really where a lot of attention has been focused on the impacts of that legislation. When we talk about prescription drug spending, we are specifically focusing on spending at retail outlets, so, pharmacies, chain stores, mail orders, department stores, and things like that. Not drug spending that occurs in hospitals or clinics or physician's offices, which are recorded in those particular service categories in the National Health Accounts. As you can see from the chart, prescription drug spending growth accelerated rapidly from 1993 to 1999, where it peaked at almost 20 percent growth. This was caused by a number of factors, and really there's a very good article in the January/February issue of *Health Affairs* by a

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colleague of ours who works in our office, Cynthia Smith, detailing the historical trends in prescription drug spending that gives a much more detailed analysis than I will give here about why historical patterns look the way they do and what the drivers of spending are. Much of that acceleration, in fact most of it was driven by increased utilization of drugs, specifically newer drugs that were high priced drugs. There were a number of new drugs that came to market during that period. They tended to be blockbuster type drugs that were heavily advertised and this coincided with a period where there was a shift in enrollment plans from sort of your traditional fee for service plans to managed care plans that tended to have much lower co pays for drugs as opposed to coinsurance. And so all those factors sort of combined led to this acceleration in prescription drug spending through the '90's.

Since 1999, as you can see, we've actually seen the opposite trend and kind of a slow deceleration in prescription drug spending. Growth was 15.3 percent in 2002. There are a number of factors, again for this slow down and we always spend a lot of time with this projection, because there's not one thing you can put your finger on that's causing everything going on this sector. There's about 100 different factors all acting simultaneously to cause the trend. But during the last few years, we've seen a fewer number of new drug introductions. We've seen a fewer number of blockbuster drugs sort of come to

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market. We've seen a drop in the number of people with private health insurance that occurred during the recession. And we've also seen some brand named drugs that have lost their patent protection and generics that have come to market to compete with those. So some of those are some of the factors that have helped slow the prescription drug spending over the past few years.

We, then, project that the slowdown will continue in the near term and actually through the entire projection period, that prescription drug spending will slow. We have growth at 13.4 percent in 2003 and then down to 12.4 percent by 2005, and there's some major factors here contributing to that slowdown.

First, the impact of the tiered benefit structures for drugs. I mentioned that earlier with the out-of-pocket payments seems to be really starting to have an impact on demand and consumer behavior, as far as which types of drugs to consume and seems to be contributing to the recent slowdown, as well as is a factor in our projected slowdown in drug spending.

We're also seeing slower growth in prescription drug price growth, as measured by the CPI for prescription drugs, which is the deflator that is used in the National Health accounts. Growth in this measure was 5.2 percent in 2002. We have that growth rate dropping to 3.6 percent in 2003, so, a significant deceleration. And again, much of that data is

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historical data as measured by the Bureau of Labor Statistics.

From our research and discussion with people in the know, we get a sense that there aren't blockbuster drugs that are in the pipeline that are expected to come to market in the next few years, so that is also contributing to what we anticipate to be slower growth. There are, however, several brand named drugs, high sales, high volume, high priced brand name drugs that are likely to lose patent protection in the next few years and so the impact of generic competition on those drugs is likely to have an effect and help slow spending growth in the next few years.

Given that, and given that the line is slowing down and it looks, how could you have drug-spending growth below 10 percent? I mean, it's been growing double digits every year. We always get this question. It's still far outpacing the rest of healthcare. Far outpacing the rest of healthcare. The growth that we have projected over the projection period is 11.2 percent on average each year, which is 4 percentage points faster than overall healthcare. Therefore, the prescription drug-spending share of healthcare increases by nearly 50 percent. It goes from 10.5 percent in 2002 to 15.5 percent in 2013. So, we do have a projection for drug spending that is slowing, but it is still far outpacing overall health spending growth.

**DREW ALTMAN:** I think you're also projecting that it

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will represent, what is it? About a third of out-of-pocket spending in 2013? More than physicians. More than dental. So, from a people perspective there's also that aspect.

**STEPHEN HEFFLER:** Right. And there is a section of the article where we discuss some of the trends in out-of-pocket spending for services that we don't always talk about, because those tend to be the services or the goods that are bought that the consumers kind of feel at the point of purchase.

Okay. Here's the dangerous part of the presentation, the sort of the qualitative impact of the Medicare Modernization Act, and I'll just do sort of a quick summary here. We do have more detailed information in the article about what we think some of the effects are going to be. As I mentioned previously, the impact of this legislation. The legislation itself is not in these projections. We do plan to update the projections at the earliest opportunity. There are a lot as everyone maybe in this room knows and have experience with this bill. There are a lot of different provisions of the bill and different parts of the healthcare sector that are influenced, and unlike, maybe, traditional legislation that tended to have an effect say just on the Medicare program, there's a lot of effects across the healthcare sector from the legislation. We have not yet had the opportunity to do the work necessary to understand those impacts fully on a qualitative basis, even, and definitely not on a quantitative basis. So, we

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don't have any numbers.

The one effect that we think we're pretty sure is going to happen, and this might be, I don't know if it's worth saying, but that's our company line. (Laughter) Is that we're pretty sure that beginning in 2006, there's going to be a significant shift in who is paying for prescription drugs. And that's going to be a shift out of private payers and out of Medicaid and to the Medicare program. The magnitude of those shifts, as I mentioned, we have not looked into.

We're not yet sure, and we haven't determined the effects on overall health spending. We do say in the article that we're not sure if the effects on overall spending in the long term will be significant or that large, but again, that's just a kind of a qualitative look at what we think the impact might be as opposed to actually getting in and doing the work. But what I think we can conclude is that our story, with or without the legislation really doesn't change much. And that story being, we do expect healthcare spending growth to continue to outpace economic growth, continue to consume a larger share of GDP and a larger share of income. Whether the number, 18.4 is correct or not, because we don't have the legislation in, I think the story itself won't change too much once we do build that legislation in.

So, with that, again I wanted to thank *Health Affairs* and the Kaiser Family Foundation for the opportunity to talk

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about our findings and I look forward to hearing the comments from the other panelists and to answer any questions that the audience may have.

**DREW ALTMAN:** Great, thank you. That was a terrific and really clear presentation of lots of complicated stuff. Who says terrific, dedicated people don't work in government, including Sam? He had lots of numbers and I think it's useful to remember that they really matter, these numbers. For example, for wages, for scoring, I don't think the founding fathers anticipated quite how powerful micro simulation modeling would be in our policy process. And so, let's get to what this all means and perspectives on it. I think we'll start with Dan and then we'll just move right on to Henry. So it's all yours.

**DAN CRIPPEN:** Thank you, Drew. And it was a very good presentation of an extremely complicated subject. I'm going to start out by playing the usual green eye shade that my pro at CBO kind of forces me into occasionally. That may be too often for most of you. But, we should start first, I guess, by talking a little bit about baseline and it's important to keep in mind here some of the foibles of any baseline, but this one in particular as you write about the specific numbers that evolve from a baseline like this.

First, as in all cases, CBO's baselines are identical in the sense that they're all projected based on an assumption

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about current law and current law being maintained over whatever the projection period is. And of course, as we know for goodwill Congress will come back to town and will change the law over the next ten years one way or another. And some obvious examples in the current healthcare baseline, particular for public programs to take note of and the authors do quite well, so you can pick it up from their paper pretty easily, things like physician payments, which were due to be cut actually under the current formulation for physician payments that are Part B. The supplemental appropriation bill prevented that from happening and assured a moderate positive update over the next couple of years, but then reverts back to the formula, which would mean starting in 2006 it would be fairly significant cuts in physician payments for Part B. You can surmise as well as I, whether or not that might happen. But there are things like that embedded in any baseline that one has to be a little careful of about assuming what's going to happen.

But the baseline is driven by some more significant factors than small changes in underlying law, and that is, of course, that the demographics which are mostly baked in a cake. Now, most people who are going to retire are alive and most people who are going to be working are alive. We have a few of those people who are retired here. (Laughter) I've been trying to figure that out. And also a piece that drives these

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estimates, at least the top level estimates, of course is something we euphemistically call excess cost growth, which for the public programs we mean on a per capita basis how fast are the programs growing, relative to the growth of the economy? And we have assumed historically that at some point excess cost growth must be driven to zero, and that is to say the program cannot grow forever faster than the economy. That's not an assumption we currently are making, however, either at CBO or CMS.

It's interesting, if you go back, in fact, as some of you probably have and look at the 1965 Liddy report on Medicare, one of the comments made by the folks doing the estimates was that in the recent past, prior to 1965, hospital costs relative to daily wages had been growing quite rapidly and the statement was made in support of the estimate that's made there for future years that this can't go on forever essentially. We can't have daily hospital costs growing faster than daily wages. Well, of course those estimates we know were somewhat low and we have had hospital costs and other costs growing faster than underlying economic factors for some time. So we finally, CBO and CMS together kind of got tired of reality hitting us over the head and a couple of years ago started saying, we don't know when excess cost growth is going to go to zero. Obviously, at some point it might have to, but for the time being we assume something greater than zero in the

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baseline and so how much that cost growth comes down, because the average for Medicare, for example, has been about 3 percent above, per capita cost has grown faster than the economy, is a very important piece of how quickly these program costs can accelerate. It doesn't take long for the compounding to take over and become much more important than the demographics of the growth in the elderly.

The second obvious point, I think, to be made here, we all keep in mind, I hope, as I try to remind you as often as I can, this ten year period to 2013 is just the beginning of an extraordinary period of demographics in which the elderly of course will retire, my generation will retire in literal droves and will double the number of people eligible for Medicare over the course of this twenty year period. And all of the implications that has for spending these trends and other things which I won't go into at this point, but we do need to keep in mind that the end of this 10 year period is just the beginning of something that we haven't seen before and it's going to happen, not just in the United States, but it's beginning to happen even sooner in some other parts of the world.

The underlying, one of the underlying pieces of this, as we have already discussed a little bit about, is what is going to happen to pharmacy spending over this period. In particular, of course, given the recent passage of the

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Medicare Pharmacy Benefit, what happens in (inaudible) pharmacy spending? Well, first, we also need to keep in mind that pharmacy spending still, and obviously this is changing as well, but it's still 11 percent or so of total healthcare spending, so it can grow rapidly for awhile and still not dominate the top level figures. But at some point, of course, it becomes an increasingly important piece of this.

As to overall pharmacy spending and what the impact will be of the Medicare Benefit, I think the authors, while they have not done a quantitative assessment have it about right. That is, one would expect that there's not going to be, I think for good reasons I'll get into, much impact on total pharmacy spending in the economy. Rather, what's going to happen is a significant shift of current expenditures from out-of-pocket, from retiree health programs, from Medigap policies onto the Medicare budget, onto the Federal Tax Budget? The reasons for that are several.

One is that even though there are a fair number of uninsured elderly today, uninsured as to pharmacy benefits, those uninsured elderly fill almost as many prescriptions a year as do the insured. That's not to say they don't, that they probably do it with some deprivation, but nonetheless, they're getting a fair number of drugs. The averages are something like 32 prescriptions a year for those who have insurance and 25 for those who don't. And so there is an obvious difference here and

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if your policy goal was to close that gap through the Pharmacy Benefit, that 7 scrips per person, per year, strictly doing the math, would be a few billion dollars of more spending. So, what's likely to happen is a lot spending occurring in other places now is going to be shifted onto the Federal Budget.

Your other reason to think that the demand inducement here might be reduced, at least when it comes to total cost. This is a large segment of the population in the elderly, which have not been subject to, or at least bigger pieces of it haven't been subject to pharmacy management heretofore. Some of them have been. Some of elderly in retiree health programs, but certainly the uninsured, much of the Medigap, even the Medicaid, frankly, has not been very well managed. And so you're going to invite at least, the legislation anticipates, pharmacy management, over this sector of the population, which hasn't had it before. And so that means things like tiered co pays and formularies and other tools that the PBMs use today to encourage generic substitution and others that would keep down. And of course the PBMs and the legislation anticipates that the PBMs will be able to, for drugs for the elderly here will be able to negotiate lower prices than the elderly pay now, so. There are any number of factors one could think about that would think that would actually reduce total spending on drugs for the elderly, but it's probably going to be something close to a wash when it's all said and done. So there's a good reason

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to believe the authors here are probably right in their assessment that the bill itself on pharmaceuticals won't much change those trends.

Third, in the overall picture of health spending and Drew's invitation to think about what can change in this inexorable apparent rise in spending, I tend to agree with his comments that the things we hear about most common today at the moment don't appear to have much more than a marginal affect, and the potential for that may be marginal as well. Things like consumer driven, or things like product disease management. And one way to think about it is to look at, of course, who is spending the money to get healthcare today? And it's well known, and this is certainly no startling fact that a relatively few or a handful of folks, no matter what class you look at drive much of the spending.

In Medicare, for example, 25 percent of the population spends 90 percent of the money every year. And so it's that group of people that are expending more, need more healthcare and in turn, whatever price increases and cost increases we're seeing are for the care of those most needy folk. And so it's those people we need to be looking at if we're going to have hope of dramatically changing these projections in the long run. And if you think about that class then, and what kinds of new innovations might apply to them, for example, the consumer driven healthcare of giving patients more money, more

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information and more decision making authority. As an economist, of course I think incentives are good and will be helpful in the long run to give people more choice and more ability to exercise that choice. But again, if you think about where most of the costs are, folks who are chronically ill and perpetually in need of expensive services, it's not clear that more money, more information and more discretion will much change their consumption pattern. If a physician tells an elderly patient that they need to be hospitalized, the amount of their co pay, the level of their deductible is probably not going to determine whether or not they go to the hospital. How many of these high cost patients and the procedures used for them are discretionary, I think is a very open question.

Likewise, the chronic disease management, while it has some possibility, particularly for these expensive folks at least in theory, so far the evidence is not very clear that it's saving money. We have some evidence on chronic heart failure, that it's possible to save money and some on asthma. So it may be that eventually the evidence will come in that these programs will come in and save money and provide better healthcare and the consequence.

But for many people, and the most expensive again, they suffer from multiple chronic conditions. It's not just chronic heart failure or just diabetes or just high blood pressure. It's all three or many other things thrown in, COPD beginning

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with the elderly class. And it's this combination of multiple chronic conditions that cry out for a better coordination of care. We know that some of these elderly folks have ten and fifteen physicians. They get hospitalized several times a year. They may have over fifty prescriptions a year and no one in the system currently is in charge of coordinating their care.

So to conclude here, one of the answers I think to Drew's question of what can be done, one has to think about coordinating mechanisms for care for the most expensive patients. And as a consequence, one might save money and change these upward lines somewhat, but I think unquestionably you could give them better healthcare if there was a coordinating function in here somewhere.

Every day we see evidence of where there are problems in the current system in which coordination would help. There was a report earlier this week, I think, or late last week about sixteen million encounters of the elderly with physicians last year resulted in inappropriate prescriptions. We know that regional variations on Medicare spending amount to about 30 percent, all of which are due to difference in practice patterns, not the conditions or outcomes. And we know these variations among the elderly who are most perpetually, chronically ill. So there are lots of places one can look at anecdotal data to suggest we can do a much better job and that job has to be done in coordination and somehow change the

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practice of healthcare so we have a coordinating function here, whether it's by physicians or by IT, by regulation, by something in order to change the underlying trends here I suspect.

**HENRY AARON:** Everybody who is interested in healthcare policy, I think owes profuse thanks to the staff of CMS for the statistics they compile on national healthcare spending. If the constitution is what the Supreme Court says it is, then healthcare spending with equal truth is what CMS says it is.

(Laughter)

While they can define the past with irrefutable authority, they cannot as yet command the future, as past forecasts based to be sure on methods that have been progressively replaced and refined amply testified. The problem is, that as forecasters they encounter every problem that other forecasters face and a whole lot of others besides.

The first problem that I'm going to focus on is captured by the simple identity that price times quantity equals outlay. Quite simply, we can measure and try plausibly to forecast outlay, but current analytic capability leaves us pretty much in the dark about how to divide changes in outlay between changes in price and changes in quantity. Recent work on heart disease and mental illness indicates that we may not even have the sign right on conventional measures of price change. To be sure, those therapies may be atypical, but rapid

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change in the character and the efficacy of treatment is typical of many forms of healthcare. The technical dynamism that hinders us from sorting out price and quantity changes should, I think, warn us that forecasts built, as are those of CMS, on separate projections of price and real consumption are subject to considerable error. But, one might reply, the focus of these forecasts really is outlay, not on quantity or price. Those are grace notes I believe in the projections. There's a patron saint of econometricians, St. Offset, (laughter) who may provide us salvation.

But, there's a second problem. By definition, we can't forecast accurately advances in knowledge, which strongly influence demand. So does public policy and the legal and political environment as the experience of the 1990's amply attests. Despite such uncertainties, the picture that emerges from the CMS projections is to my eye at least, entirely plausible. Boiled down to its essentials, the projection is that overall health spending is going to grow about as fast in the future as it has grown on the average over past decades. We have just gone through two periods that we now think were abnormal. One of unusually slow growth in healthcare spending and one of unusually rapid growth in healthcare spending. The slowdown occurred after the debacle of the Clinton Health Plan. Managed care picked low hanging cost containment fruit, picked the frightened hospitals and hospitals half to death

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with the possibility of fines and imprisonment under the False Claims Act. Frugality and cost containment were in the air. Then managed care discovered that slowing the growth of healthcare on a sustained basis would take, not just buying in bulk and paying doctors under incentive contracts, but genuine rationing and the public recoiled. Hospitals and physicians could down code their claims only so far and the underlying dynamic of rapid, sometimes price reducing, but nearly always cost increasing technological advance reasserted itself. Short of its detail, the CMS projection is that recent trends were first, too cold, then, too hot, and now they're going to be just like historical averages. Does that view make sense? The honest answer, I think, is that no one really knows.

The reason no one knows is that total healthcare spending is an enormously complicated interaction among population dynamics, economic growth, technological advance, and politics. We can forecast population quite well over the next decade, the period covered by the CMS projections. We're not really very good at forecasting real economic growth, as evidenced by the productivity collapse of the 1970's and '80's and the productivity resurgence of the 1990's, both of which, remain only partly understood.

Our ability to forecast technological advance is even worse for the simple reason that the core of technological advance is filling our current ignorance. And then there's

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politics, about which the less said the better. (Laughter).

Each is important. The state fiscal crisis is causing retrenchments on Medicaid coverage, which Medicaid recipients are not well positioned to make good and these bulk significantly in the CMS projections. President Bush has proposed to block grant much of Medicaid, which would change state incentives to provide this benefit. Every Democratic candidate has put forward major health initiatives that would cover roughly half to three quarters of the currently uninsured, whether one of them becomes President and persuades Congress to enact major extensions of coverage is at once central to the trajectory of healthcare spending and enormously uncertain.

The pace of technological advance could accelerate as many who follow molecular medicine suggest, or it could slow down as the apparent slacking off in the introduction of the new blockbuster drugs, again which was mentioned initially.

Current growth in economic productivity affecting the denominator is truly extraordinary, further from the historical trend I might add, than has been the deviation in the growth of healthcare spending from historical trends in the last five years, but no one knows whether it will continue. No one even knows whether the current economic recovery will be sustained or abort. But what I've said here is mostly truism. Everybody knows it. But what it means is that the projections of

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healthcare spending growth are highly uncertain in both total and in detail.

With this uncertainty in mind, I have one good concrete idea and it's a plagiarized idea, I steal it from Dan Crippen. I would urge CMS next year to publish something analogous to the fan chart that the Congressional Budget Office began to issue, I think under Dan's direction. For those of you who haven't seen it, that chart uses past forecast errors to indicate deviations around the central prediction of the budget deficit that historical experience indicates will occur with varying probability. So you have a measure of the uncertainty. A similar chart, at least for total healthcare spending or for personal healthcare spending would remind readers that formulating projections for something that is, let's be frank, beyond our capacity accurately (inaudible) is an art and not a science.

Despite all of these concerns, attention, I think, should be paid to a projection that healthcare spending will grow in the future at about the same rate that it has grown on the average for the past four decades. That growth rate, well in excess of trend growth in national income should remind everyone that healthcare spending is going to continue to put pressure, not only on public budgets, but on private budgets as well.

As far as public budgets are concerned, the clear

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implication, not so much for the next decade as for later years, is that the United States faces an inescapable and hair-raising choice between gutting the key elements of the social safety net, Medicare, Medicaid and Social Security, or significantly raising taxes, possibly by 40 or 50 percent of their current levels.

The pressure on private budgets is going to depend more sensitively on whether productivity growth descends from currently astronomic levels. If it does, as most economists suppose, the tug of war between employees and employers over who should pay for care is going to intensify as healthcare costs keep going up. The pressure to ration care, in earnest, will also rise.

In closing, I want to relate a true story about the methods of projecting healthcare that are used in the CMS projections. There is one global forecast, then there are separate forecasts of detailed components of healthcare spending that are independent, and then there is reconciliation of any discrepancies at the end. When I was in college, a friend took an introductory Calculus course from a math professor who had served on one of two commissions charged with projecting population. One was forecasting the population of Los Angeles County and the other, the population of the State of California. When they finished, they concluded that the population of Los Angeles County would eventually exceed that

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of the State of California. (Laughter) I'm sure they, too, had some reconciliation procedures in mind.

**DREW ALTMAN:** It certainly feels like it does.

**HENRY AARON:** Thank you very much.

**DREW ALTMAN:** Thank you Henry. So I wrote down "entirely plausible, but no one really knows" and "hair-raising choices." We would love at this stage, thank you both, to open it up and get everybody involved. I ask only that you tell everybody in the room who you are before you ask your question. Susan.

**SUSAN:** (Inaudible) prescription drug spending and this sort of intriguing supposition that the only discernible outcome would be a shift from the private spending portion to the Medicare spending portion. It seems to me that if one believes that, one also believes that there will be no expanded demand for drugs because of the new benefit. No moral hazard. No induced demand, which doesn't quite ring true to anybody who's ever walked into a doctor's office and been asked, "Do you have insurance?" before the doctor takes out his prescription pad and writes a prescription. So, I guess I'm wondering how that story makes any sense in the great scheme of things. Dan, I think you said it would maybe be a few billion at best. It just doesn't seem plausible and it would seem that if, in fact, to pick up on Harry's point you had a fan, you might have a pretty dramatic tail to that fan that would presume some considerable expansion and demand.

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**DAN CRIPPEN:** I think there are a couple of things that make it perhaps, more plausible than it seems. One is the recognition that even though we have a significant number of uninsured elderly when it comes to pharmaceuticals, three quarters or some number and the authors use a point in time estimate that they have cited of close to 40 percent of elderly may not have pharmaceutical insurance. So it certainly is a significant number of people, no matter which measure you use. But, nonetheless, those who are uninsured are currently consuming pharmaceuticals. As I said, the difference between, on an average scrip basis, the difference is only 7 per year, that is between the insured and uninsured with some broad variance in here. So, the uninsured elderly, when it comes to pharmaceuticals are still getting pharmaceuticals, again maybe at great deprivation to themselves, their kids, lots of things that one would worry about, but they're getting a fair number of pharmaceuticals. So it's not clear that there's going to be a great new induced demand that will be written by doctors and demanded by the patients. Certainly there will be some of that and one would, whenever you're lowering the price or changing the apparent price for people, they're going to change their demands, but as I suggested, there are also some very strong mitigating factors I think out there. The increased inducement, the potential is smaller once you recognize that the uninsured are getting a fair number of drugs, but then on the other side

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as well you have things like pharmacy management techniques being applied to this population that have never been, for many of them never been utilized, whether it's through co pays or formularies or other things that the management industry has used in the past. And you have for this population one of the advantages of having a national benefit. And part of the debate, of course, is whether the Federal Government is better off doing this or private pharmacy managers, but you're still going to have large bodies of consumers represented, to which these folks can take in their negotiations with prices from drug companies. So, again, there are a lot of mitigating factors against what has to be, your assumption has to be right. There will be some induced demand, but what I'm suggesting is that the potential for that is small given that uninsured elderly get a lot of drugs today and that there are a lot of pressures on the other side if this legislation works the way anticipated to hold down pricing.

**DREW ALTMAN:** Anyone else want that one? I don't want to operate on the usual procedure that everyone responds to every question, but if somebody else wants to jump in on that one? Okay. Other questions. Yes?

**MALE:** I'm with the Congressional Research Service. My question is for Stephen. He talked about how in the near term there is a decrease in healthcare spending and two of the reasons; among the reasons were these two. That there is a

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decrease in the growth in enrollment in public health insurance and there's a decrease in enrollment in private health insurance. So am I reading between the lines that you're saying that there's an increase in the number of uninsured that is contributing to the decrease in healthcare costs? And if that's true, then what are your assumptions regarding the uninsured and quantitatively that impact on your projections?

**STEPHEN HEFFLER:** Over the past few years, 2001 and 2002, we've seen about a cumulative 1 percentage point decline in the number of people with private health insurance. Our projection for 2003 is that there will not be a drop in the number of people with insurance. That it will be essentially flat and that growth will then return to a more positive range in the 3/10 to ½ percentage point range over the next few years in 2004 and 2005. The implication of that is that population growth averages about .9 to 1 percentage point per year, so the implication is there are more people with insurance. There also are more people without insurance. So I think that's maybe the best way to sort of summarize what our thoughts are about what's going on in the private insurance enrollment phase. It's a little tricky because there's a lot of numbers out there about what the right number is of the number of people uninsured. We try to stay out of that because there are so many data sources, we don't want to throw another one out there that people are quoting. So that, as far as growth rate, that's sort

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of what the projected pattern is over the next few years on the private health insurance side.

(Inaudible question)

**STEPHEN HEFFLER:** Given our numbers of private health insurance enrollees and the population that is the implication of it. What we don't do is give an actual number, because as I said there's so many numbers out there they might not always match and so we're sort of, you know, a little hesitant to throw out "This is the number of people without insurance when"

**DREW ALTMAN:** And you thought the drug bill would be the hot question. Thank you for that. Henry, did you want to?

**HENRY AARON:** I just wanted to say that the right answer to your question, that is that it depends sensitively on the course of the economy and on the fiscal situations of state and local governments. If we have a rousing boom, if this recovery continues and productivity is rapid and unemployment begins to come down, we're going to see private insurance coverage increase, the fiscal plight of states and local governments improve significantly, cutbacks in Medicaid will slow or cease and may reverse, and we could begin to have a pattern that we saw in the late 1990's when there was a substantial increase in work-based insurance coverage. On the other hand, if this jobless recovery stays jobless and stagnates, state and local governments are in deep, deep trouble and employers are going to be under continuing pressure. So I think the answer to your

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question about insurance coverage needs to be contingent on the future course of the economy.

**DREW ALTMAN:** Great. Other questions? Yes?

**TONY FOG, *Modern Health Care*:** Can someone comment on some of the different ideas out there, especially among the Presidential candidates of how to bring healthcare costs down and what it may have the impact of your projections, specifically malpractice reform.

**DREW ALTMAN:** Henry's anxious. Steve, you can have it.

**HENRY AARON:** I want to say the same thing that I was saying and that I heard Drew say on the radio. I believe it is a serious mistake to try to parse in detail the nuance differences among the Democratic candidates. The message that I believe you take away from the statements made by the Democratic candidates is that health insurance coverage is back as a national issue. It's one that they are persuaded resonates with the American public. No one of them is going to be unduly constrained should he be elected by statements that were made in the pre-nomination phase of the campaign. What you get will be a commitment to an issue and the usual suspects who accompany a Democratic President as advisors and you're going to see, I think, a pragmatic approach to a problem, probably with a willingness to put more money and Federal Government presence behind it than is the case with President Bush. I'm not taking a stand here on which of those approaches is the

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better one, but simply urging that the focus should be on the issue and the willingness of each of the candidates to speak out on it, not on the detailed differences of each of their proposals.

**DREW ALTMAN:** God, I hate moderating. I'll just say, Amen. Other questions? Yes?

**ALLWIN KASTLE, Center for Studying Health System**

**Change:** I actually have a technical question for Stephen. Your hospital line item, does that include both inpatient and outpatient spending for hospital services?

**STEPHEN HEFFLER:** Yes, it does.

**ALLWIN KASTLE:** And does it also include affiliated ambulatory surgical centers that are affiliated with the hospital, not freestanding facilities?

**STEPHEN HEFFLER:** Facilities that are affiliated with the hospital are included.

**ALLWIN KASTLE:** So that the aggregate hospital spending and the home health and nursing home spending associated with hospital spending are there. Okay. With that clarified.

**STEPHEN HEFFLER:** (Inaudible) skilled nursing facility then home health agencies are also included in the measure of hospital.

**ALLWIN KASTLE:** Spending.

**STEPHEN HEFFLER:** Correct.

**ALLWIN KASTLE:** Given that. How do you calculate? There

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has been such a rapid growth of ambulatory surgical centers and this ties into your projection that more procedures will move to outpatient settings. How does the growth of the ambulatory surgical centers, some of which are owned solely by physicians, but many of which are joint ventures between hospitals and physicians. How does that impact on your spending projections for hospitals?

**STEPHEN HEFFLER:** The method we use for projecting spending in hospitals and physicians doesn't get as detailed to projecting it by specific type of facility on the private side. Now the public sector payers, particularly Medicare, there are specific line items projections for the amount of spending for ambulatory surgical centers, hospital based home health facilities and so forth that are then wrapped into this projection. On the private side, the projection is done at more of an aggregate level. As Henry mentioned, we do the projections in total, in aggregate to try to pick up some of these shifts implicitly whether they be between prescription drug spending and care that used to be done inpatient, now is handled through the pharmacy or clinics. And then we reconcile that with sector specific projections that are done on a more aggregate level than at sort of the detailed facility level type projections. So we don't have any specific projections and we don't have a detailed way to handle that. We do it on a more broader aggregate level and then try to incorporate to the

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extent we can, information that we would have on what maybe some of those trends are and call on St. Offset or whatever Henry said, to try to build in any judgmental factors that we would think aren't being picked up specifically by our model that we have. So that's kind of the process of how we handle projections for each sector.

**DREW ALTMAN:** Great. Kaiser will buy lunch for those who want to discuss methods later today. (Laughter) A nice lunch. Any other questions? Yes?

**CARL PULZER, Independent health policy analyst:** I guess, pretend like somebody from outer space came down and they didn't real know about all the political barriers around. As analysts, as economists, is it necessary to try to slow down healthcare spending? Should we be concerned about it and two, given what the Federal Government does now to provide incentives for spending, like an open ended tax inclusion for benefits, putting billions of dollars into medical research, what would be the most effective ways it could behave to slow down the spending? And if it chose to constrain the amount of tax loopholes for insurance, but you wanted to get more insurance to lower income people, maybe you'd want to? How would you do that?

(Laughter)

**BACKGROUND VOICE:** Do you want a conference?

**MALE:** Let me say one, and it's not necessarily a point

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of view, but certainly worth your consideration, one of the folks that Henry and I and others speak on panels with occasionally has just authored a book, a fellow Harvard who, it's called "Your Money or Your Life" and in which essentially argues healthcare is obviously worth what we pay for it or we wouldn't be willing to pay for it and therefore one should not be as concerned about the increases as you might otherwise be and we can clearly afford this no matter how you calculate it. There's obviously some controversy surrounding that point of view, but that's a legitimate point of view and maybe we're overly concerned about increases. I think from a budget perspective, if you will, and Henry certainly cited this, as you realize not only what's going to happen over the next ten years or the next thirty and the growth of healthcare costs and the Federal budget, particularly for the elderly and what the implications are there for the budget. I think it becomes critically important to recognize it, if we do nothing else. Because it will, on its own inexorably require a significant increase in taxes to pay for current commitments. Some taxes well above this country at least has ever experienced in the past. It may well be worth it, but if we don't face up to these facts, the rest of the budget could be squeezed considerably or these programs could be squeezed to the point where they are no longer anything that looks like a safety net, let alone a viable protection for elderly retirees. So the fact that these

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things are growing, may not in some national sense be as worrisome as we think they are standing up here or sitting here. But the implications for the budget and other spending in the economy can be pretty profound.

**DREW ALTMAN:** Perfect. Okay. Anybody else want to get into this? John?

**JOHN MACDONALD, *Hartford Current*:** One of the problems that people in my business have is that we end up having to summarize this in bumper sticker style. So one bumper sticker could be, this is good news because the rate of healthcare spending is not going up as fast. The other bumper sticker could be that's it's still bad news because the rate of healthcare spending is still rising much faster than the rate of spending overall. So now, I would invite the panel to give me your bumper sticker.

**DREW ALTMAN:** I'm sure we'll see both headlines around the country.

**HENRY AARON:** I don't think it's right to cast the expenditure trends as good or bad news. If one were writing press copy for the computer industry, increased expenditures would be good news for the industry and the economy, because people were showing they wanted to buy this stuff and it was worth it to them. The right question to ask, I think, is the kind of question that Dan was getting at in his comments, which is whether we're spending it well. And there's a great deal of

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evidence that we are spending it very far from perfectly, that we make a great many mistakes, that we don't have proper case management for the elderly seeing a dozen doctors, that doctors do not adhere to standards of practice consistently, Weinberg's studies in the Dartmouth Project. The Dartmouth Project are crystal clear on that subject. My sense is we're probably doing a bit better now than we have done in the past. That the attention to cost control has increased sensitivity to how funding is spent, that competition for managed care for all its flaws may have had some benign effects systemically, but that we have a very long way to go. The real message of rising costs, I think, are not so much for whether it's inherently good or bad news, but for the consequences that rising spending have in various areas. What does it mean for government budgets? It means a hell of a lot of trouble. What does it mean for private budgets? It means a continuing tug of war between employees and employers over who pays and hence is a source of contention and difficulty. I think those are the implications of the rising numbers, not whether the numbers themselves are good or bad news.

**DREW ALTMAN:** Right. Anybody else? Okay. We'll take a couple more and then I think we're past our time. Yes, in the back?

**MITCH PATTERSON, Burness Communications:** Understanding that these are national expenditure numbers, do you have any

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demographic or regional breakdowns as to urban versus rural changes in what these expenditure projections will be?

**MALE:** No, we don't. We just do the projections at an aggregate level. We do build in demographics, as far as population growth and sort of the age gender mix of the population, but we do not do projections by area or by age or gender. There are historical estimates that our office produces on those measures. The data is a little more difficult to get to and to work with and so it tends not to be as timely as some of the aggregate data. But that information is available on the CMS website where the other health accounts data is.

**DREW ALTMAN:** Okay, we'll do one more question. You had your hand up.

**STEVE HITAWB, National Health Law Program:** This question is for Steve. In reaching your conclusion that Medicaid spending might slow down, might decrease. Did you attempt to distinguish between numbers of people on the program and cost of services being provided to people who were on the program? Is that question clear?

(Inaudible)

**STEVE HITAWB:** That's a product right? Number of people spending so much per person and so either you could have fewer people on the program spending the same amount per person and have a slowed down expenditure or you could have either the same number or presumably greater number of people on the

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program each getting a weaker benefit spending less per person and reaching the same conclusion, and I wondered if you looked at?

**STEPHEN HEFFLER:** The projections for Medicaid that we incorporated into this, Chris, let me know if I'm right, into this projection is based on the official Medicaid projections that come out of our office that is broken down into both enrollment growth and per person growth. The slow down in 2003 is a combination of both slower growth in the number of people coming into the program, as well as slower growth in the per person spending of people that are in the program.

**DREW ALTMAN:** Go ahead.

**MALE:** Just one quick footnote here, because one of the things that the authors didn't have time to do was to look at the Medicaid impacts of the pharmaceutical benefit and one of the differences, frankly between CMS and CVO is how much Medicaid will save because pharmaceutical benefit expenditure for the elderly now being incurred by Medicaid will transfer to the Medicare budget, and so it's some tens of billions of dollars in here that will switch from one budget to the other and therefore cause a difference in apparent Medicaid (inaudible) without any change in enrollment or services.

**DREW ALTMAN:** Great. Well, Kaiser will certainly like ending on a Medicaid note. (Laughter). First of all let me thank those who are watching this around the country and it

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might surprise you, it actually it turns out that it's usually around the world. We will get emails, you know, from Australia that say, "What is this St. Offset?" (Laughter) and Larry Levitt will have to respond to them. I'd like to thank the panel very much and especially Steve and his colleagues for doing this critical work every year. I propose we do this event every year now and thank you all for coming.

(Applause)

[END RECORDING]